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ABSTRACT

A Title XX funded statewide training program offering 20 hours of instruction for 1,662 licensed center and home child care providers who served Title XX eligible children in Michigan was evaluated at the end of its first year of operation. The first three chapters of this evaluation report discuss (1) the history, philosophy, and goals of the Michigan Day Care Provider Training Project; (2) the evaluation design for measuring trainers' attitudes and expectations, their knowledge and skill, as well as their behavior in the child care setting and the behavior of children in care; and (3) the structure and organization of the evaluation project. The following three chapters describe three aspects of the training process: the population trained, the trainers, and the format, course content and structure of training. Outcomes of training are reported in the concluding chapters. Trainers' perceptions regarding strengths and barriers of the program, plus their satisfaction and session evaluations are indicated, and trainees' perceptions of training, their child care attitudes and knowledge, as well as observations of nine trainees' caregiving behaviors are reported. Unanticipated outcomes are discussed. The final chapter provides a summary of evaluation findings and resulting recommendations. Evaluation instruments, background project data, and project enrollment maps are appended. (Author/RH)

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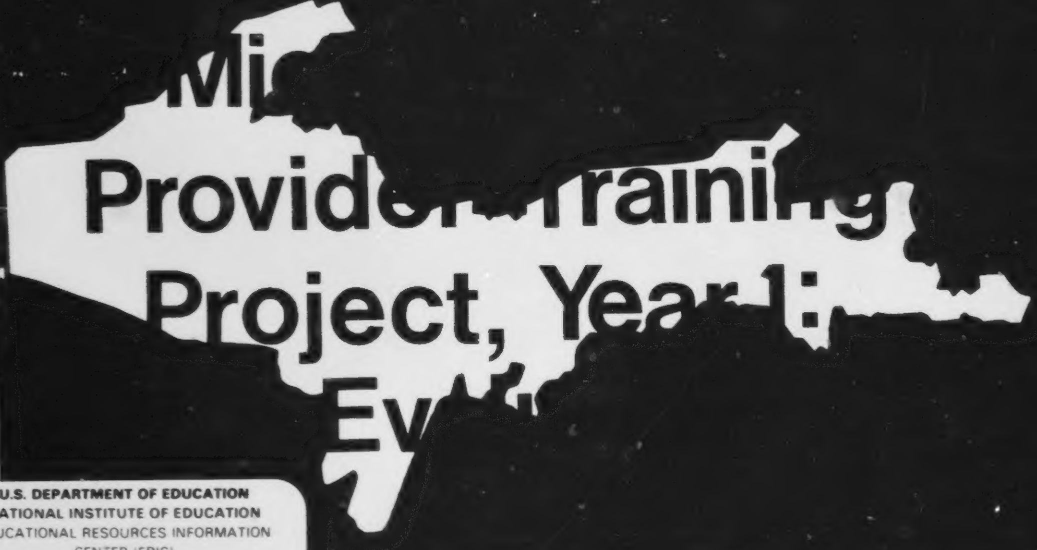

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MICHIGAN DAY CARE PROVIDER TRAINING PROJECT, YEAR ONE: AN EVALUATION

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CENTER FOR URBAN STUDIES

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January, 1981

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THE MICHIGAN DAY CARE PROVIDER
TRAINING PROJECT,
YEAR ONE: AN EVALUATION

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THE MICHIGAN DAY CARE PROVIDER TRAINING PROJECT, YEAR I: AN EVALUATION

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THE TRAINING INSTITUTIONS

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Alpena Community College - Alpena

Delta College - University Center

Department of Family and Consumer Resources,
Wayne State Univeristy - Detroit

Family Day Care Council of Michigan, Inc. -
Ann Arbor

Grand Traverse 4-C - Traverse City

Grand Valley State College/
Kirkhof College - Grand Rapids

Kalamazoo Valley Community College - Kalamazoo

Kirtland Community College - Roscommon

Lake Superior State College - Sault Ste. Marie

Mercy College - Detroit

Mott Community College - Flint

Saginaw Intermediate School District - Saginaw

University of Michigan - Ann Arbor

Wayne County Community College - Detroit

Acknowledgements

This evaluation addresses the total composition of this statewide training effort. Therefore, as promised at the outset of the evaluation, individual subcontractors are not compared or separately evaluated. It was their individual efforts and commitment on behalf of provider training which made this report, and the impressive number of trainees who benefited from this project, possible.

The responsiveness and cooperation of the child care providers trained in this project provided a special kind of support to this evaluation. It is really this group, which performs such a significant, yet often unacknowledged, role in our society to whom this work is dedicated.

Melissa G. Kaplan
Sue Marx Smock

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Chapter 1

Overview

During a period of three months in 1980, 1662 licensed center and home providers throughout the state of Michigan were enrolled for twenty hours of professional training under the provisions of Title XX of the Social Security Act. This report presents an evaluation of this important training program. The Michigan Department of Social Services viewed this as the first in a series of such training programs. Therefore, the major function of this report and the project evaluation discussed herein is to present data and analysis which hopefully will help in planning and implementing future day care provider training.

With this is mind, this first chapter will discuss the history, philosophy and goals of the Michigan Day Care Provider Training Project: Year One. It will end with a description of the remaining sections of the report.

History

Training for day care providers has long been a goal of the Michigan Department of Social Services (MDSS). This goal was shared by many parents and providers as well as by educators and social workers who deal with children and their families.

When Title XX of the Social Security Act went into effect October 1, 1975, a broad interpretation was made by some states to allow use of Title XX funds for training. These expenditures, though having to be matched (25% local to 75% federal) were thought to be beyond the state limit for Title XX funding. Michigan did not make this liberal interpretation of the Title XX expenditures at that time. It was not until June of 1979, when proposed revisions in the Federal Interagency Day Care Requirements (FIDCR) were published in the Federal Register and included a training requirement for day care providers, that Michigan moved to implement such a training program. This move resulted from the development of a support cadre within the State Legislature, which allocates Title XX funds. The move toward day care provider training was encouraged by two factors. The potential mandate in the regulations for training made Michigan's efforts prudent and gave the state a headstart on the to-be-mandated training. Second, the expenditure for training would not cost a penny of state revenues, since 75% of the funds would come from the federal government and the 25% local match would be provided by the local institutions doing the training. The continued education and informational work with the State Legislature on the part of the enlightened Day Care Services Office of the MDSS, promoted and undergirded by a committed Day Care Advisory Committee to the MDSS, can be credited in a large part with the development of the training program.

In May of 1974, the Day Care Advisory Committee to the Department of Social Services, chaired by Pearl Axelrod, Special Assistant to the Dean, University of Michigan School of Education, appointed a Task Force to make recommendations for the training of day care providers. The chairperson of the Training Task Force was Evelyn Linden, Day Care Consultant to the United Community Services of Metropolitan Detroit. The Task Force included professionals from institutions of higher education, a consumer representative, persons from community coordinated child care programs and staff members from both the Department of Social Services and the Michigan Vocational Rehabilitation Services (see Appendix B for a complete list of Task Force members).

For 18 months the Task Force devoted hundreds of hours to interviews with day care personnel at every level, a review of the literature, an overview of resources and demographic data, and an exploration of many training concepts. In November, 1975, a report of the Training Task Force was published by the MDSS. This Task Force report reached the following conclusions:

> The purpose of training is to move toward quality child care.
>
> The most important single element in quality child care is the competence of the caregiver.
>
> A qualified caregiver requires skills and knowledge beyond those of parenting.
>
> There is a body of knowledge that day care workers should have.

There is a demonstrable interest in training among day care personnel in Michigan.

There is a demonstrable need for training among caregivers as well as child care personnel who do not come in direct contact with children, e.g., DSS child care staff.

This report, issued in the midst of a serious economic recession, had to await four years for implementation. In 1979, the Michigan State Legislature allocated some of Title XX funds for the training of licensed caregivers who serve Title XX eligible children, or who are certified with a contract and a rate to serve these children. The Office of Management and Staff Development, directed by Dr. Gilbert Fisher III, placed the implementation of this grant in the Service Training Division, directed by Felix Younger, and within the section of Adult, Family and Employment Development Training. Horst Orth, Supervisor of this section, in turn, appointed Roger Nelson as the Project Officer. A state-wide Project Advisory Committee chaired by Pearl Axelrod assisted with the selection of the master contractor and with all subsequent work of the training project. This committee included parents, providers, academicians and representatives of the MDSS Day Care Services and Licensing Division, as well as the MDSS Training Division.

A Request For Proposal (RFP) for a master contractor was issued by the MDSS on December 7, 1979. Because of a technical flaw in the original procedure, there was a second beginning of the RFP process in February, 1980. Thus, both in January, 1980, and again in April, 1980, the selection committee awarded the training contract to Wayne State University's Center for Urban Studies (CUS/WSU); Council on Early Childhood .

CUS/WSU chose to articulate some of the basic principles outlined in the RFP by designing a two level approach to training delivery. As "master contractor", they would set the parameters and act as facilitators while subcontracting to local institutions throughout the state of Michigan to conduct the actual training. Indeed, the Michigan Day Care Provider Training Project, Year One is the work of CUS/WSU and fifteen Michigan subcontractors.

Finally, as a framework for discussing this training program, the most significant events and the time frame within which this activity took place should be kept in mind. The most significant events during the training period are as follows:

April 11, 1980 - CUS/WSU was awarded the Michigan Day Care Provider Training Project for project development, training and evaluation in the amount of $440,878 in Title XX funds with a local match of $152,322. (This was later reduced; see June 30, 1980.)

April 14, 1980 - Commence RFP process for potential subcontactors.

April 29 and 30, 1980 - Pre-proposal conferences held in Gaylord and Detroit respectively.

May 14, 1980 - Master contractor met with the Project Advisory Committee, MDSS staff and selected professionals to help select subcontractors.

May 15, 1980 - Master contractor staff notifies subcontractors by telephone of the acceptance of their proposals for funding.

May 22 and 23, 1980 - Pre-contract orientation sessions were held with trainers and financial officers.

June 2-19, 1980 - One-day orientation workshops held throughout the state with local MDSS staff and subcontractors, attended by the Project Officer and master contractor field representatives.

June 23, 1980 - First Educational Training Unit (ETU) began at the Saginaw Intermediate School District.

June 30, 1980 - The contract funds were reduced by MDSS to $381,150 Title XX monies with local match of $127,050. In turn, subcontracts were adjusted accordingly. This reduced the number to be trained.

August 19, 1980 - Conference was held for subcontractors to answer questions and to give information about final reporting procedures.

September 30, 1980 - Final training is completed.

October 3, 1980 - Final subcontractors' meeting to share information, evaluations, and to make recommendations.

October 8, 1980 - Final meeting of the Project Advisory Committee to assess the training program and to develop recommendations for future training.

Definitions

The use by MDSS of Title XX funds assumes specific interpretations of certain concepts. The most significant for understanding this training program are:

Day care: the care, supervision, and guidance of a child, on a regular basis, for periods of less than 24 hours per day, in a place other than the child's own home.

Day care center: a place in which day care is provided to more than twelve children.

Day care home: a private residence in which day care is provided to twelve or fewer children.

Caregivers: all persons who provide for some period of the day, direct care, supervision, and guidance of children in a day care center or home. This includes - part-time employees, volunteers, and substitutes as well as staff who are not normally caregivers, (such as bus drivers and cooks) who provide direct care for any part of the day.

Eligibility for Title XX Training: Those day care providers who are licensed and certified to care for Title XX-supported children, with an established rate for such care.

Philosophy

It seems clear from the proposal written by CUS/WSU that some philosophical commitments guided the development of this project. In one sense, a philosophy had been outlined in the conclusions reached by the Training Task Force in 1975, as well as in the two principles established by them for provider training. As stated previously, this philosophy stressed the key role of caregiver competence in the provision of quality child care and the feasibility of training to boost that competence. In addition, the ideas of tailoring training to meet the needs of different providers, and of tangible recognition for participation in training, were emphasized. Thus, the providers' needs were considered an essential element in finalizing plans for training programs.

The CUS/WSU project strongly reaffirmed these goals. In addition, the underlying philosophy of the master contractor seemed evident in three basic areas: (1) the general orientation to the content area, (2) the endorsement of specific philosophical viewpoints concerning child care, and (3) emphasis on local community control of training specifics by the subcontractors and their trainers.

First, the general orientation of this training project acknowledged the contributions of two related but somewhat distinct bodies of knowledge: the field of early childhood education and the field of human development. The fact that both were recognized sources of input in the form of resource persons, trainers, subcontractors, texts, and other written materials, meant that the project had broad-based support. Although all persons concerned with the project shared goals and experience related to child care, they did not all share the same philosophical or educational background. While many training projects endorse a particular educational model and philosophy, this project did not appear to align itself with one model of early education and development at the expense of another. Consequently, a variety of professionals worked together enthusiastically to plan and implement the project.

Second, specific viewpoints drawn from early childhood sources and from principles of human development were endorsed by the project. For example, there was a positive attitude toward supporting parents, teaching children about ethnic diversity, accepting children's curiosity and the growth of autonomy, physically reassuring upset children, recognizing the importance of fantasy play and of consistent caregivers for young children. There was a negative attitude toward physical punishment and low evaluations of the worth of particular learning activities. These viewpoints were not promulgated in any single document or curriculum, however. The master contractor used the following three approaches to communicate these viewpoints:

1. the choice of subcontractor
2. the initial two day, subcontractor/trainer orientation meetings
3. the coordination and monitoring function of the field representatives.

A third philosophy emphasized in this project was that of local planning and control of the schedule, location, and type of training that was offered. It was assumed that training would have most appeal when it was developed to fit the needs of providers in a particular region. Child care was viewed as a service intimately linked to lifestyles and, therefore, likely to vary somewhat from region to region. In addition, there was an emphasis upon local community support for training because of the need to establish linkages and programs that could be continued in some form after this project was completed. The subcontractor system, which emphasized local control of almost every aspect of the program, except for evaluation and liaison with the MDSS, was utilized in keeping with this philosophy. As a result, a variety of training schedules, strategies, and formats were not only expected but encouraged. Such tolerance of variety and ingenuity demanded both that the master contractor trust the local subcontractors and that its commitment to local control be a consistent, strongly felt one.

While guided by a particular child care philosophy, this project nevertheless incorporated professionals from various backgrounds and utilized the child care teaching resources within the providers' own communities. It was both broadly based in its inception and narrowly relevant in its delivery.

Project Goals

It is important at this point to delineate the specific goals of this project. These goals derived from the philosophy of the master contractor, the report of the Training Task Force (1975), as interpreted by CUS/WSU, and the requirements of the contract with MDSS. The following were stated as the goals of the master contractor:

1. Training will be presented in some or all of the topic areas designated by the master contractor. This training will be grounded in the sound human development and early childhood education principles needed for the provision of quality child care.
2. Both center and home providers will be trained.
3. A minimum of seventy-two ETU's will be conducted that will enroll at least 1420 eligible providers (according to the Amendment to the Master Contract, June 30, 1980).[1]

---

[1] The original contract (April, 1980) stipulated that a minimum of 12% and a maximum of 20% of eligible providers would be trained. The total number of eligible providers was estimated by MDSS as 13,965 in January, 1980, so that 12% was 1676 eligible child care providers.

4. Training will be offered in some part of all former nine MDSS regions to insure training availability statewide.

5. Local community linkages will be developed between providers and resources so that support for day care and a useful coordination of effort will continue after the project is concluded.

6. The training unit (ETU) will have the following characteristics:
   - a. 10-30 trainees per ETU
   - b. twenty hours of training for each trainee
   - c. some on-site training whenever possible
   - d. course credit at the college level for a trainee (upon completion of the full twenty hours of training), whenever possible.

7. To maximize the relevance of training to local needs, the training format and the choice of topic areas from the list of fourteen areas specified by the master contractor will be decided at the local level.

In addition to an evaluation of the goals stated above, this report will examine data and information as requested by MDSS in their contract for the evaluation of the program.

The following chapter will describe and discuss the evaluation methodology; then chapters three through six will describe the process by which project implementation occurred; chapters seven through nine analyze both the anticipated and the unanticipated outcomes of the project. The last chapter summarizes the conclusions and recommendations arrived at as a result of project evaluation findings.

Chapter 2

Methodology

This section will include a discussion of the evaluation design, its limitations, and recommendations for future evaluation of this project. The training project had certain structural components which, in turn, placed specific constraints on the methodological design of the evaluation.

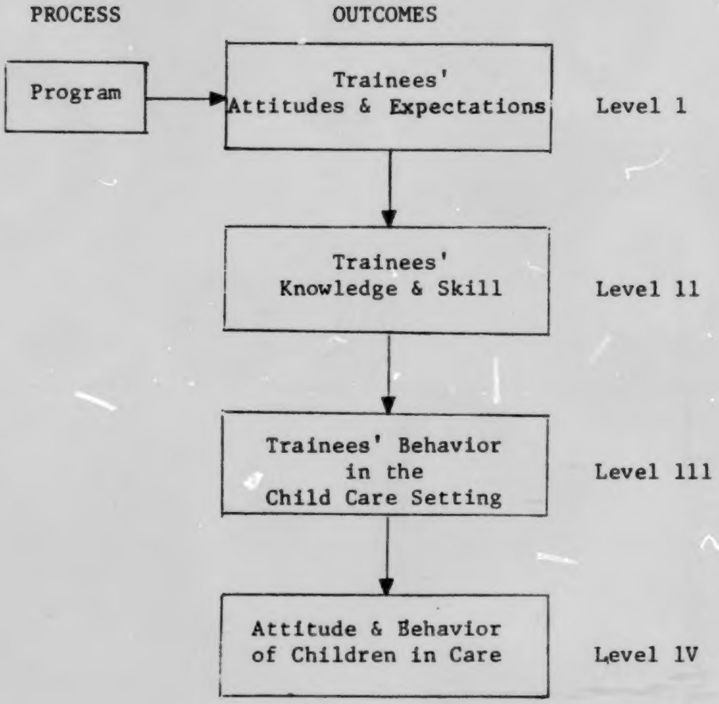
First, as indicated elsewhere, the time between contract authorization and the need to commence training was incredibly short. As long as the evaluators wanted baseline data and wanted to include all subcontractors, these overwhelming time constraints affected the evaluation design as well as the project.

Second, this was very much a first-year project. There was no information regarding the characteristics of trainees, or, in fact, the trainers. Further, there were almost no knowledgeable expectations with regard to variability across the state. This was as much an initial program for the subcontractors as it was for the master contractor. Therefore, evaluation forms had to be acceptable to a wide range of educational levels.

Third, the training program was designed for optimal local input. As a result, each subcontractor designed his/her own programs within the constraints set by the master contractor. Obviously, for evaluation purposes this raised a question with regard to whether there should have been a uniform evaluation or separate ones designed specifically for each subcontractor.

The goals of this evaluation were related to the assumed progression of training outcomes (as indicated in Figure 1). The initial decision of the design was to determine which of these could be measured with reasonable validity and reliability given the constraints of the project under consideration as well as of the general "state-of-the-art."

Figure 1
LEVELS OF EVALUATION


PROCESS
OUTCOMES
Program
Trainees' Attitudes & Expectations
Level 1
Trainees' Knowledge & Skill
Level 11
Trainees' Behavior in the Child Care Setting
Level 111
Attitude & Behavior of Children in Care
Level 1V

Because this was the first of what was anticipated as a number of provider training programs, measuring the program process had very high priority. On the other hand, the geographic spread, subcontractor variation, and time constraints were such that not all of the program process could be meaured with equal detail. For example, the recruiting process is analyzed from subcontractor reports rather than evaluator observation; at the same time, detailed data were collected regarding the characteristics of those recruited, as well as trainer attitudes, expectations and the topics that were covered in each session. The design included the collection and analysis of data from all structural and content components of the project.

Since prior knowledge about child care providers was so minimal, great stress was placed on the analysis of the first level outcome: initial expectations of training and attitudes regarding training. Since there could be wide variation among subcontractors as well as within (by ETU) there was no "safe" sampling procedure which could be devised prior to training. Therefore, these data were gathered from all trainees.

A most difficult issue for the evaluation team was the second level outcome: the trainees' knowledge and skill. The major goal of the training project was after all, to affect knowledge and skill. The first issue was related to the decentralization of program planning. Since it was assumed that each subcontractor would select from the total competency topics what would be taught, the actual content would vary between ETU's. There was not time to cover all topics in which trainees needed skill-building even if the subcontractor could reliably determine this. The issue for evaluation design was one of whether or not to measure only the content topics to be covered in each particular ETU. To do so would have the advantage of assessing precisely what was accomplished in that ETU. The other alternative would be to use one comprehensive instrument for all ETU's which would result in more information regarding provider knowledge across the state. The latter course was taken. Since this was a controversial decision, a few of the major reasons should be noted:

1. Many subcontractors were uncertain as to exactly which topics would be covered, in which sessions, or whether there would be more than a brief introduction to the topic.

2. No validated knowledge test could be found for these competency topics which was appropriate for this anticipated population.

3. Since each subcontractor determined his/her own course content, there was no reason to believe that even within the same topic, different subcontractors would teach the same items or sub-topics. Therefore, even if only specified topics were measured, it could still be claimed that the knowledge/information instrument did not measure what was actually taught. At the same time, differential instruments would lose the advantage of the singular comprehensive instrument.

4. A singular comprehensive instrument would in fact, measure the knowledge/information level of all the trainees in all topic areas. This, in turn, would be an important aid in planning for future training.

At this time it can be stated that given the variety of training components and the number of on-site and last minute decisions which were necessary for the subcontractor, hindsight convinces us that specialized instruments would have been impossible to administer.

The evaluators believe that Level III can be measured once the prior level measurements are perfected. Therefore, in an attempt to begin this process, one singular measurement of trainee behavior outcome (Level III) was attempted in one small subgroup. This will be discussed in Chapter 8. With regard to Level IV, as illustrated in Figure 2 below, there was never any intention of including these in the evaluation design.

In essence, then, the general approach of this evaluation was one of closely analyzing the training process with particular emphasis on (1) describing trainees, (2) training topics and formats, and (3) trainer characteristics.

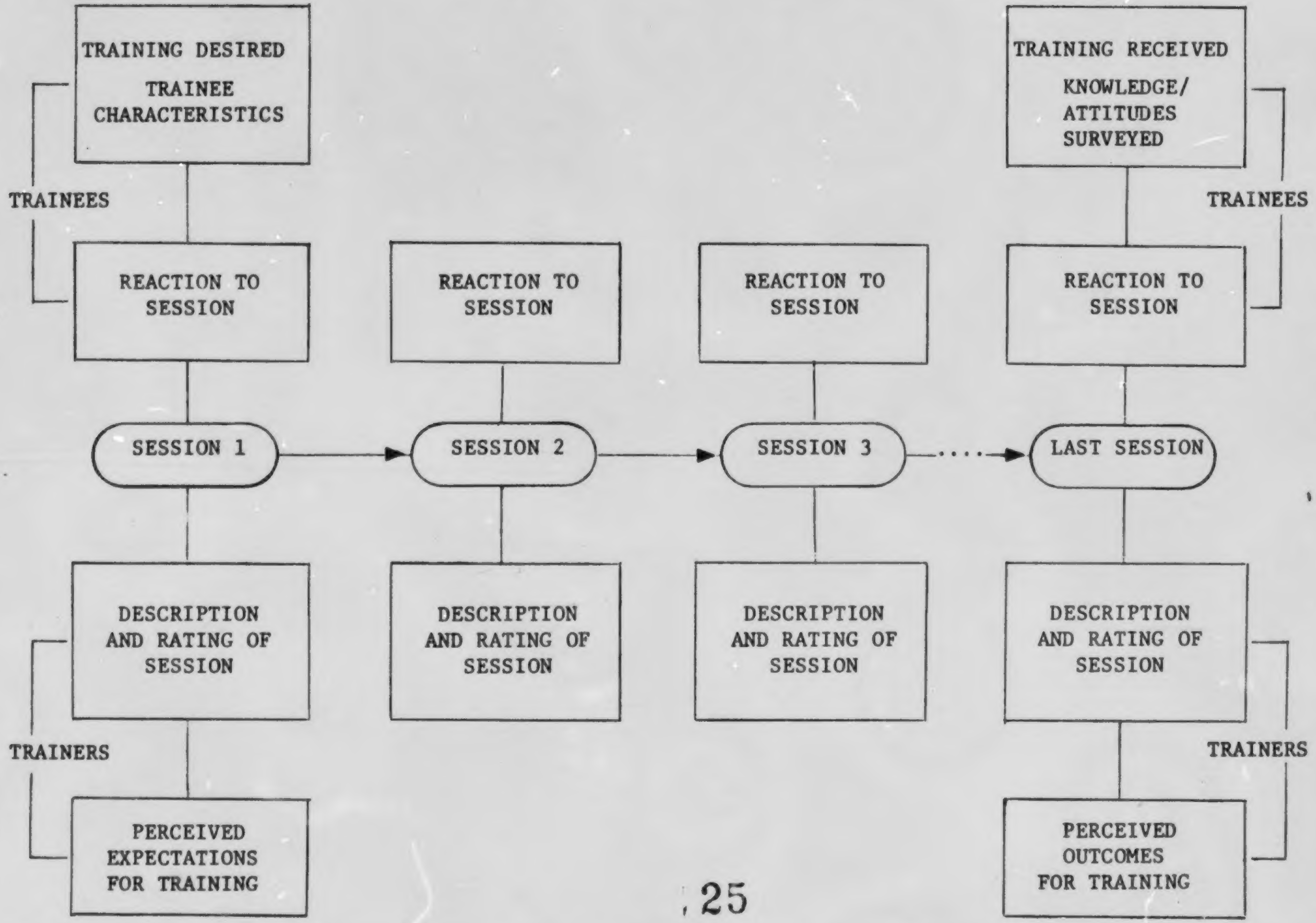
These data would be used to learn about what type of training was offered, who are the providers (trainees), and the effectiveness of decentralized training. These, in turn, led to an analysis of outcomes regarding trainee attitudes and knowledge about child care.

Procedure

The basic procedure for measuring the process and outcomes of this first provider training program was very detailed. It was anticipated from the start that future evaluation would involve less detail and redundancy. Much of the evaluation procedure was structured around the individual training session; measurements were taken at each session. This is shown schematically in Figure 2 below. Such detailed measurements allowed for anticipated variation from session to session in the reactions of both the trainer and the trainee.

Figure 2

Model of Selected Data Collection


TRAINING DESIRED
TRAINEE CHARACTERISTICS
TRAINEES
REACTION TO SESSION
REACTION TO SESSION
REACTION TO SESSION
TRAINING RECEIVED
KNOWLEDGE/ ATTITUDES SURVEYED
TRAINEES
REACTION TO SESSION
SESSION 1
SESSION 2
SESSION 3
LAST SESSION
DESCRIPTION AND RATING OF SESSION
DESCRIPTION AND RATING OF SESSION
DESCRIPTION AND RATING OF SESSION
DESCRIPTION AND RATING OF SESSION
TRAINERS
PERCEIVED EXPECTATIONS FOR TRAINING
TRAINERS
PERCEIVED OUTCOMES FOR TRAINING

Trainee and Trainer Perceptions and Basic Data. As indicated, data concerning the characteristics of trainees were collected at the first session (see Appendix A for questionnaires). Trainee perception of the session and trainer description and perception of the session were collected at each session. There was some difficulty because of all-day sessions. In a few cases more than one form was completed by trainees during the same session. This usually happened during all-day sessions when there were definite breaks in the session with corresponding changes in the trainer.

These evaluation forms were usually distributed by the trainer or facilitator since it was impossible for the evaluators to be present at all training sessions. The evaluation team did observe training for twelve of the fifteen subcontractors. Reports were made and these data are part of this evaluation.

In addition, trainers' perceptions of training strengths and barriers were assessed at the initial and final sessions of every ETU.

Measuring Knowledge. An instrument was devised and pre-tested which measured knowledge in the competency topics specified by the master contractor. As indicated in Figure 2 and discussed earlier, this was administered in 94 of 95 ETU's at the end of training. The key question, of course, involved changes in knowledge and information as a result of training. One common method for assessment of such change is the pre-post design; that is, the measurement of people's knowledge prior to the training and the measurement of their knowledge after training. Any changes in their scores (in the positive direction) are then attributed to the course work itself. The evaluation team decided to use this design in a minimum of ETU's only toward the end of the project due to a number of factors. This design had a number of disadvantages for this particular program:

1. As indicated earlier, there is no validated knowledge test available that covers these competency topics for this population. The time constraints of this project did not permit the creation and validation of such an instrument.

2. There was concern regarding the degree to which trainers might teach to the evaluation instrument. Further, some training was of such short duration that the reactive potential of the pre-post design would be of concern. If they taught to the evaluation test given at the first session, there would never be a measurement of the effect of training without the evaluation. In other words, any improvement might depend upon the combination of being pre-tested and then having training. Future training probably will not involve a pre-test; therefore the above results would not be predictive of future training results.

3. The original design included mailing some of the instruments to the potential trainees to be completed before training began. This was not feasible. As a result, there was considerable paperwork at the first training session, before people were involved with the project. The pre-test would have added to that problem.

Considering these disadvantages, the pre-post test design was utilized only with selected ETU's. Pre-tests were given in seven ETU's of subcontractors which started training late in the year. Selecting the last few ETU's allowed the evaluation staff time to examine some of the post knowledge tests. This insured the fact that there were no major difficulties with the knowledge questionnaire as an instrument which could be comprehended by the trainees. At that point, the literacy level of the trainees was clearer to the evaluation staff.

At the same time, another alternative to the pre-post design was utilized; this was the contrast group design. It involves giving the trained providers the knowledge questionnaire only after they have completed training and, administering the questionnaire to a like group of providers who have not had the training (contrast group). Theoretically, this design, like the pre-post test assumes that differences in scores are due to training. That is, one can assume that if the untrained providers score lower than the trained providers, the difference in scores is due to training, assuming that the two groups are equivalent on influential characteristics. The one disadvantage of this design is the difficulty encountered in finding comparable groups. A group of providers who had originally indicated a desire for the training, but never enrolled in training, were sent the knowledge test and asked to complete it.

Thus, there are two groups for comparison with the post knowledge measures. A small group for whom a pre-post design was used and a group of home providers who appeared comparable to the trained home group but did not receive training. These comparative measures are discussed in Chapter 8.

Drop-Outs. The original design included telephone interviews with a sample of trainees who did not complete training. Unfortunately, these could not be administered due to incomplete records as well as the time and financial constraints. This is an important item for the evaluation of a program; therefore, in the future, records should be kept to facilitate this task.

Administration. Interviews were conducted with a sample of subcontractors to determine their appraisal of and relationship with the master contractor. Further, extensive observation of the master contractor was conducted but the primary measure of the master contractor is that of goal attainment.

Anonymity and Confidentiality

The overwhelming time constraints, particularly at the beginning of the project, were reflected in the evaluation operation as well as in the project itself. During the planning phase, the evaluation team never had the time to talk with subcontractors, trainers and trainees regarding the purpose and role of an evaluation. In such situations, evaluations tend to be viewed with great concern and suspicion; this was a complicating factor regarding specific procedures in this project. There were strong objections to the policy of requesting trainees to sign their session forms. On the other hand, the original evaluation design included tracking trainees through the training process. Therefore, in a desire to reach some compromise, it was agreed that "maiden names" could be used. This obviously has a great many problems all of which were encountered in this project. It became impossible to track a large number of trainees due to the inconsistency in the names they signed to their forms.

A second issue arose involving the evaluation forms which trainees completed after each session. Since there was no prior knowledge regarding trainee responses or confidence in themselves as trainers, the evaluation team decided that it could be dysfunctional for trainers to read individual responses. Further, even with substitute names, confidentiality was at risk. Therefore, all forms were sealed by the respondent. This caused great concern among some trainers and subcontractors who wanted this immediate feedback from the trainees after each session.

A procedure was developed to give them some grouped data once the evaluation team had received the completed training session instruments. This process took from one to five days. Few took advantage of this opportunity. Admittedly, it was cumbersome - the trainers or subcontractors needed to initiate a telephone call and often it would be at long-distance rates.

Future evaluation can avoid both of these issues by more comprehensive communication prior to the training. The evaluation team is convinced that respondent identification will be important in measuring change, particularly as evaluation instruments are improved and become more sensitive to differences in training.

At the same time, confidentiality must be maintained. Therefore, the evaluators would still recommend a procedure whereby respondents seal their completed forms. However, future evaluations should not necessitate measurements at each training session which aggravate the situation. Better understanding of the evaluator's role prior to training and more efficient feedback should eliminate negative feelings on the part of trainers and subcontractors.

Chapter 3
Project Organization

This chapter focuses on the structure and organization of this project. As previously indicated, CUS/WSU thought it best to have training responsibility maintained at the local level where it could be adapted to local needs. This was articulated in the concept of a "master contractor" who acted more as a facilitator and a group of regional "subcontractors" who, with the master contractor designed training and then individually implemented it themselves. This concept was probably the single most important reason that CUS/WSU was awarded the initial Day Care Provider Training contract. Thus, by necessity, the evaluation and discussion of this project organization must move back and forth between these two levels.

The Role of the Master Contractor

In consultation with the Project Advisory Committee and the MDSS Project Officer, the role of the master contractor was:

1. to establish the goals of the training.
2. to choose subcontractors from various areas of the state who could provide this training in a flexible and practical way to meet local needs.
3. to work with the MDSS to appraise local Department of Social Services workers of the training project and to secure their suggestions and participation.
4. to provide needed technical assistance to the training institutions.
5. to implement a state-wide needs assessment, using instruments developed by Bush Fellows at the Department of Education, University of Michigan in 1978-79.[1]
6. To provide maximum cooperation with the evaluation team in securing necessary data and in any assistance requested in the development of information for the evaluation report.

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[1] This assessment was implemented but is not part of this evaluation.

These functions were carried out with an operating staff which consisted of a program director, assistant program director, two field representatives and secretarial support staff. There was also a CUS/WSU staff member who handled billing and the extensive fiscal considerations once they had been progammatically determined.

The Selection of Subcontractors

Working on a very tight time table, CUS/WSU, with the help of the MDSS Project Officer, prepared a subcontractor Request for Proposal (RFP) which was published over the weekend of April 18, 1980, in newspapers with statewide circulation. In addition, the MDSS mailed RFP's to the broadest possible list during the week of April 21, 1980. This list included state colleges and universities, all community colleges in the state, the four state councils, child care and development organizations such as the Michigan Association for the Education of Young Children and the Michigan Cooperative Nursery Council, as well as to individuals and groups who had expressed an interest in the project. Pre-proposal conferences were held in Gaylord and Detroit on April 29 and 30 respectively.

On May 14, 1980, the master contractor met with the Project Advisory Committee, MDSS Project Officer, and five community volunteers from the early childhood field to review proposals. The twenty-one proposals which had been received were rated according to the guidelines established in the CUS/WSU Request for Proposals:

> All proposals will be evaulated by the CUS/WSU. Consultation will be sought from MDSS and the Project Advisory Committee. Criteria considerations for selection of proposals, on the basis of which a contract will be offered might include, but will not be limited to, the following:
>
> A. Acceptance by both sets of trainees (center staff, home providers) as an organization perceived as a legitimate source of training.
>
> B. Capacity, within the time frame, to assess local needs for training and to deliver the training in a manner suitable to the trainee group or groups involved: the necessary managerial, trainer and other responses.

C. Resource or capacity to generate 25% local match (in-kind, if a public organization; cash if not).

D. Linkages and relationships with appropriate training and service group within the area.

E. Prior and successful involvement in similar training activities for similar trainees.

F. Eligibility under Title XX.

Other desirable factors include: commitment to a continuing involvement in this type of training. On-going or project programs providing progressively advanced training leading to certificate or degree.

On May 15, 1980, sixteen institutions were notified by telephone that they were selected to be the training institutions for this program. Subsequently, the two in the upper penninsula combined, leaving a final total of fifteen subcontractors. It should be noted that, especially considering the time pressures, the complex process of subcontractor selection appeared to be well implemented. This included a great deal of concentrated work on the part of everyone from MDSS to the volunteers to the CUS/WSU staff.

Description of Subcontractors

The fifteen subcontractors covered a broad area across the entire state (see Map 1). They are described in Table 3-1 below. The subcontractors represented several different types of institutions and agencies: state universities (two subcontractors), a state college, two-year community colleges (seven subcontractors), an intermediate school district, a 4-C Organization, a Family Day Care Association, a day care center complex, and a private four-year college. Thus, eleven of the fifteen subcontractors were institutions of higher learning and most were public institutions as had been anticipated. It was more difficult for private organizations and agencies to participate because of inhibitions regarding matching funds. That is, Title XX requires a twenty-five percent match. For private organizations, this must be in the form of monies whereas an institution which is defined as a "government controlled public entity" can have an "in-kind" match.

As indicated in Table 3-1, the number of courses, or what were called Educational Training Units (ETU's), and persons trained, varied considerably from one subcontractor to another. It appeared to be dependent upon their own decision at the time of the proposal as altered by their experience during the recruiting and planning period. The actual type of training also varied a great deal; the training itself is discussed in chapters four through six. Suffice it to state here that there was certainly variation among subcontractors as each designed training according to what they considered to be the needs and facilities in their own locale. This was, indeed, what the master contractor had anticipated.

Master Contractor Coordination

It was the role of CUS/WSU as master contractor to provide assistance, curriculum help and general consultation to the subcontractors. The evaluation team, through on-going, direct observation of the master contractor staff activities and interviews with subcontractors, obtained some specific indicators of this part of the master contractor role.

In the 3 1/2 months in which training took place, the CUS/WSU program staff made at least one visit to each subcontractor in addition to the orientation sessions. Many hours were spent on the telephone. Three state-wide conferences for trainers were held at Wayne State University and CUS/WSU field staff participated in training sessions organized by the subcontractors locally. As subcontractors developed curriculum materials, an effort was made to share these in conferences and through the two editions of the training newsletter, The Focus, published by the master contractor. On the whole, there was a very positive attitude toward the master contractor. There appears to be little doubt that the CUS/WSU program staff had great concern about the training and empathy with the problems and needs of the training institutions. Almost all believed that CUS/WSU was available, by phone, whenever necessary and at least made an attempt to help.

Table 3-1

Selected Information by Training Institutions

Subcontractor	Type of Institution	Number of ETU's	Number Enrolled			Credit Option
			Total	Home	Center	
Alma Day Care	Private non-profit day care provider organization	6	96	34	62	No
Alpena Community College	Two-year community college	2	27	23	4	Yes
Delta College	Two-year community college	7	118	17	101	Yes
Family and Consumer Resources/WSU	Four-year state university	1	14	14	0	Yes
Family Day Care Council of Mich.,Inc.	Private non-profit corporation	5	64	64	0	Yes
Grand Traverse 4-C	Private non-profit corporation	7	124	67	57	Yes
Grand Valley State College/ Kirkhof College	Four-year state college	10	186	49	137	Yes
Kalamazoo Valley Community College	Two-year community college	10	179	17	162	Yes

(Continued)

Table 3-1 (page 2)
Selected Information by Training Institutions

Subcontractor	Type of Institution	Number of ETU's	Number Enrolled			Credit Option
			Total	Home	Center	
Kirtland Community College	Two-year community college	4	39	18	21	Yes
Lake Superior State College	Four-year state college	7	135	44	91	Yes
Mercy College	Private four-year college	12	230	50	180	Yes
Mott Community College	Two-year community college	7	110	38	72	No
Saginaw Intermediate School District	Intermediate school district	5	108	97	11	No
University of Michigan	Four-year state university	8	141	22	119	Yes
Wayne County Community College	Two-year community college	5	91	16	75	Yes

There was less consistency regarding personal trips; from the viewpoint of CUS/WSU staff, they made as many trips as time and money would allow. This became particularly difficult when one considers the logistics of training schedules. One might travel to the upper part of the state and, in four days, be able to include only two training sessions since they each had different schedules and times. Most subcontractors believed that the personal contact was sufficient, especially in light of the easy access by phone. In fact, many viewed the limited visits initiated by CUS/WSU staff as supportive of local initiative and responsibility about which they were very pleased.

A few, on the other hand, would have liked more personal contact with CUS/WSU as well as greater technical support. Although available by phone, some made the point that this contact was costly to the training institutions since in almost all cases it meant long distance fees. Often, more had been spent than budgeted for telephone calls already, in an attempt to clarifiy contract definitions. This can be rectified in future programs which encompass a broad geographic area by budgeting and installing a telephone with an 800 area code.

There was one area of serious problems which concerned definitions of several very important contractual and fiscal items. The subcontractors believed, for example, that there was confusion regarding who was eligible for training, what was an "in-kind" contribution, and which institutions could make "in-kind" contributions. These appear to be such basic items that one would expect clear and stable definitions. It was this expectation that made the indecisiveness and changing definitions particularly frustrating to subcontractors. Although these problems subsided as the project progressed, some problems remained throughout the contract period.

This was not, however, a matter of a lack of decisiveness on the part of the master contractor. In some cases, they needed to obtain definitions from MDSS. Further, these were not as simple as it appeared. The Project Officer's interpretation, based on project intent and goals, had to be mediated by the concerns of the state auditor's office. These complications and potential differences were exacerbated by time pressures which called for immediate response, when further consultation and notification to others would have been in order. Furthermore, some difficulty and changing definitions are to be expected in the initial year of any project. Many difficulties are really not known until definitions are operationalized. This program contained more than normally anticipated and, what is even more important, since a planning period was almost nonexistant, there was no time to work these out prior to actual usage.

The master contractor anticipated that they could aid subcontractors in linkages with support organizations. In one such effort, the MDSS organized orientation sessions for MDSS workers and subcontractors in every area of the state where a subcontractor was training. Master contractor's staff joined these sessions and this became the critical beginning of communication on behalf of the project between MDSS and the training operation. However, some subcontractors suggested that the local MDSS workers learn about the program earlier and in more detail. In that way, they could be more helpful in recruiting potential trainees as well as provide support during the training. This certainly can be acheived in the future with more extensive planning meetings and broader newsletter circulation.

The master contractor anticipated being a major source of curriculum resources. In fact, the project director stated that this would be the most important support they could give the more inexperienced trainers. Only a few of the subcontractors mentioned this expectation in their discussions of the role of the master contractor. In fact, it would appear that it was primarily CUS/WSU who had expectations of greater resource input than time or priorities actually permitted. Their input was much greater with regard to technical areas.

In essence, as one views the interaction of the master contractor's staff with the staff of the training institutions, it is evident that a most important contribution was that of psychological support. It must be remembered that for some of these training institutions, this was their first experience in day care training. For a few it was their first contract and a complicated one at that. Since there had been so little preparation time, all the psychological support available was needed. In addition, most subcontractors looked to the master contractor for badly needed technical help. If the field representative did not know the answer to a question, she would pass it on immediately to project management; they, in turn, would discuss it with MDSS if that was necessary. Most subcontractors perceived that the master contractor attempted to respond appropriately.

A number of subcontractors said that they had not known what to expect from CUS/WSU prior to starting the program. When the program was completed, they felt that the master contractor had a positive philosophy of child development, was supportive regarding local control, really worked to be certain that the training succeeded, and that they were accessible.

The philosophy and structure, as imposed by this program, entailed local control of training with a master contractor as facilitator and processor. This really leads to two questions. Could one central contractor without any subcontractors achieve the same results? This question is addressed both directly and indirectly throughout this evaluation report. On the other hand, assuming that a number of local institutions are needed, is a master contractor necessary? Why couldn't each training institution contract directly with the MDSS? The answer to this is more readily seen in the discussion above. As a matter of fact, CUS/WSU as master contractor, did play a major role during the initial year of this project in organizing the training and setting a framework within which each local institution could operate. If it seemed difficult to obtain consistent definitions of important technical matters with the present structure, it would have been nearly impossible if fifteen separate groups had to interact with MDSS. Thus, the technical resource and liaison provided by CUS/WSU was most important.

In addition, CUS/WSU functioned in two other roles which were of major significance. First, was the relationship with the Project Advisory Committee which is discussed elsewhere. Second, the project management played a significant role as advocates for this training and in encouraging others to be advocates. This becomes increasingly significant in a political arena with limited funds. It also has the secondary effect of enhancing the feelings of control so important to day care providers.

Obviously, it is the opinion of the evaluation team that the master contractor for year one had a significant contribution which could not be duplicated by separate local training institutions. Further, it is probably true that this role will be necessary in the future. The function of the master contractor will undoubtedly change. That is, psychological support will never be as necessary or primary once the initial phase of the program is over. Technical support and resources will always be an important role for the master contractor, but if it does not become secondary, it indicates a lack of planning. That is, many of the problems encountered in the initial year should be solved and therefore eliminated. Further, the experience of the initial year should allow for anticipation of some technical problems which can then be solved during the planning stage. This, in turn, will allow the master contractor to provide more curricula resource in the future. At the same time, they will be able to act as liaison for transmitting appropriate experiences from one training institution to the others using the newsletter, The Focus, and other important means.

Obviously, future programs must include more planning prior to actual training. There are some necessary components to future planning which were absent during the initial year. These include clearly articulated roles for the field representatives, more planning conferences for subcontractors to clarify expectations of them as well as technical needs, evaluation plans, and various substantive issues. It will also be important for the master contractor to play a strong role in organizing some of the more important state-wide resources; there needs to be more consistent knowledge and interaction with local MDSS offices as well as regional Child Care Coordinating Councils.

Although lack of planning time causes confusion, it allows for a great deal of flexibility and local determination. Thus, if the master contractor continues with future day care training programs and maintains the appropriate and necessary planning, it will need to guard against losing this flexibility. Further, there is a danger of too much central help which, in fact, turns into centralized control. Certainly, it has been the commitment of this master contractor to avoid these dangers.

The Project Advisory Committee

A Project Advisory Committee with members from across the state assisted the MDSS in the selection of the master contractor and acted in a consultative role to the master contractor throughout the project. The committee outlined and defined its ongoing role in the Day Care Provider Training Project as follows: (1) to provide advice to the master contractor from the committee members in their respective areas of competence, (2) to assist with public relations for the project, (3) to act as "ears" for the master contractor, gathering as much information and reaction about the project as possible, and (4) to interpret project policies to others in the community.

The Project Advisory Committee was unusually committed to this project and to the goal of provider training. They were consistently involved in obtaining information about all parts of the project and in providing feedback. Details of recruitment, evaluation, scheduling, and content were discussed in their meetings as well as the kinds of child care philosophy being taught. There was a strong sense of a commonly shared goal within this group which was shared by the CUS/WSU staff. This sense of working together for the same goal appeared to allow for open discussion in areas of disagreement within the committee or between the committee members and the master contractor. Discussions were supportive and constructive with no other agenda in mind except quality child care provider training.

In addition to its involvement in project activities for this initial year, the committee took an advocacy stance. The following are two examples:

1. They responded to the reduction in payments for child care announced by MDSS in the summer of 1980 with concern. It was suggested that the MDSS Research Department study the impact of these cut-backs on the children and families affected.
2. Several members met with key persons in Lansing and Ann Arbor, made telephone calls, and wrote letters to express their concern that training for child care providers be available again in 1981.

In summary, the Project Advisory Committee was by no means a token group. They met six times between May and October of 1980 to aid in the development, implementation and evaluation of the project. Their activities were carried out with a remarkable spirit of commitment to and support for relevant provider training in the state of Michigan.

Chapter 4
Process - The Population Trained

MDSS Survey

In anticipation of the tasks involved in recruitment and in obtaining county-specific training needs assessments, the Social Services Training Office of the MDSS mailed out a survey on May 7, 1980. Eleven thousand training announcement letters and survey (sign-up) sheets were mailed to all certified and licensed day care homes and centers in the state. A total of 1,626 responses were received (a response rate of 14.8%). All of the sheets returned by home providers and some of those from center providers expressed the intent of only the person completing the form. Many returned by center directors, however, indicated the total number of potential trainees in their centers. The following table presents the total number of trainees, involved in the survey returns for both center and home providers. From this extensive survey, it appeared that 2,795 (total

Table 4-1

MDSS Survey Returns by Home and Center Providers

Desire For Training	Providers			
	Home		Center	
	Number	Percent	Number	Percent
Yes	676	48.6	1,630	94.5
Not sure	286	20.6	61	3.5
No	428	30.8	35	2.0
TOTAL	1,390	100.0	1.726	100.0

N.B. For detailed data, see Appendix B.

of "yes" and "not sure") potential trainees were interested in training during the summer of 1980. As the agreement between MDSS and CUS/WSU stipulated an enrollment of at least 1420 providers during the training period, it seemed the population of potential trainees was adequate to meet this criterion.

Recruitment

Various methods of recruitment were utilized to arrange for registration of trainees. Two comments were frequently made by subcontractors relative to recruitment:

1. For those who started training early in summer, the time period available for recruitment was not sufficient.
2. Individual telephone contacts with providers were often necessary since this was a new training program with relatively little advance information available about it.

Subcontractors were able to use the MDSS sign-up sheets to obtain the names and addresses of home providers. However, as previously reported, names and other information relative to center providers had to be obtained by notifying center directors who had filled out a summary form for their entire staff. Telephone contacts were time-consuming, but almost unavoidable, for those ETU's that started early in the training period. At least one subcontractor provided a toll-free, 800 area code number for providers to call for registration and information. This method was used in conjunction with a flyer describing the training that gave the number. Such a procedure was necessary for this subcontractor since training covered a large number of widespread counties. It might be appropriate for others, even in more concentrated areas.

The most widely utilized recruitment procedures were printed flyers, announcements to local child care organizations, and telephone calls to individual providers. Child care licensing consultants and county MDSS persons helped with recruitment in some areas. Some subcontractors reported meeting with providers in their centers or elsewhere to describe training and register interested providers. Less frequently reported were the use of newspapers, radio and television.

It was recognized during the Project that MDSS cut-backs in funding for the care of certified children, during the summer of 1980, affected recruitment of trainees as well as their morale. Some subcontractors reported that potential center trainees sometimes did not enroll as their continuing employment in child care was uncertain. In some communities, there was a lack of understanding of the funding source for training. Resentment surfaced concerning the fact that while funds were not available to maintain the level of payments for the care of certified children, they were available for provider training. Correction of such misinformation was not always possible. Thus, recruitment in these areas was undoubtedly affected by this attitude.

A great deal of work and extra effort went into the recruiting process on the part of the subcontractors. Some of this is inevitable in the first year. However, more lead-time for coordination of information with local MDSS and child care organizations is needed in the future. Printed brochures, press releases, and so forth, from the master contractor would be of benefit in some areas of the state.

Obviously, whatever difficulties were encountered, the end result was successful. From June 23 until September 28, 1980, subcontractors recruited to obtain trainees from fifty-seven counties across the state and offered ninety-five educational training units (ETU's). Some training occurred in all nine of the former MDSS regions.

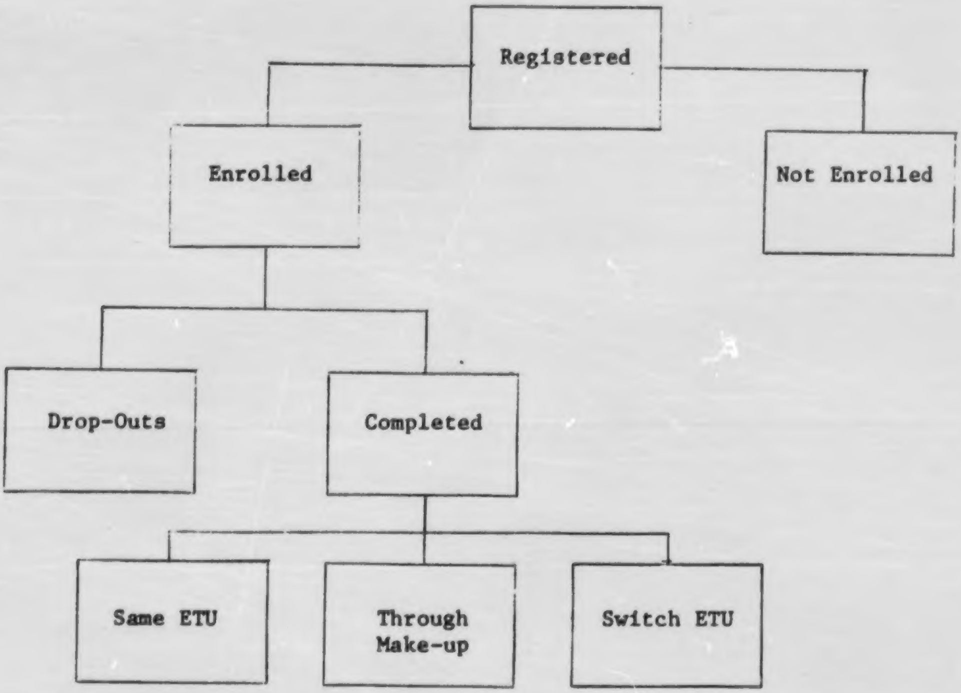
Definition of Trainee Status

With few exceptions, the various subcontractors were successful in recruiting providers to enroll for training, and thereby, met the requirements of their agreement with CUS/WSU. However, enrollment was not synonymous with completion. This became evident to subcontractors as they attemped to put together an ETU with twenty hours of training for a minimum of ten enrolled, eligible providers as indicated in their agreements with CUS/WSU. It became obvious that the process was even more complicated as the evaluation team attempted to track some of the initial trainees.

As indicated in Figure 3, the first step for many subcontractors was registration since many of these ETU's were part of a college course credit system. Thus, the problems were the same for this child care provider program as college administrators struggle with -- how do you predict class enrollment from registration. This becomes particularly difficult when no fee constraints are imposed. The problem was more acute in the recruitment of home providers than it was for center providers since the latter were more often recruited, enrolled, and trained as a group through their center. (The various training models are described elsewhere).

Figure 3

Status of Potential Trainees


Registered
Enrolled
Not Enrolled
Drop-Outs
Completed
Same ETU
Through Make-up
Switch ETU

While the rigidity of "twenty hours of training" was an important requirement of this project, all subcontractors did not agree upon what satisfied this requirement. For example, some believed that homework assignments or book reports could substitute for session attendance while others required a make-up session. The initial question was to decide when an individual would be classified as a "drop-out". Second, what structure should be used to help avoid this loss? Unfortunately, this definitional problem was not anticipated so that no operational definitions were prescribed. In those cases where the structure was that of a college course, it was evident that standard procedures were used. The course was offered and providers fit their own schedules to the course and met the requirements in order to complete or "pass".

Other alternatives were offered as indicated by the three ways of completing training shown in Figure 3. Some subcontractors offered one or more make-up sessions for an ETU; others offered a combined make-up session for providers from all of their ETU's; still others began their ETU's at different times; thus, their providers moved from one ETU to another.

This problem has been described in some detail because it becomes important in three main areas: (1) as future contractual definitions are examined especially where reimbursements are involved, (2) as curriculum requirements tend to become operationalized, and (3) as pre-post measures of knowledge are developed and used.

On the one hand, contingency plans must be available for an optimal number of providers to flow through the training process. At the same time, some system, with documentation, must be put in place which defines eligibility status.

Trainees Surveyed

Extensive efforts were directed toward obtaining evaluation data from all of the trainees. The success rate was high considering the inevitable difficulties involved in communication and paperwork for a project being implemented by fifteen different subcontractors across the state of Michigan. As explained in Chapter 2, the trainers out in the field had to be relied upon, to a great extent, to distribute, explain, and return the evaluation instruments. The following table presents the number of providers who completed the initial and final trainee forms on which this report is based, as well as the number of providers recorded on attendance lists maintained by each trainer.

Table 4-2

Number of Trainees: Enumerated in Attendance Records and Described by Evaluation Forms

Source of Information	Number of Trainees	
Attendance Records	Enrolled	Completed
Home Providers	570	501
Center Providers	1,092	862
TOTAL	1,662	1,363
Evaluation Forms	First Session: Number Who Completed the Caregiver Information Survey	Last Session: Number Who Completed the Caregiver Survey
Home Providers	487	376
Center Providers	958	717
Forms with missing info.	69	143
TOTAL	1,514	1,236

It is indeed remarkable that assessment data were collected for more than ninety percent of those persons who enrolled and eighty-three percent of those who completed training. In general, the trainers were exceptionally cooperative in responding to the requests of the evaluation team. Given the time, geographic and travel constraints, it is unlikely that a higher rate of response could have been achieved by modifying evaluation procedures. Most important, the following description of enrolled populations, therefore, is quite inclusive.[1]

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[1] Tabulation of data indicated that no more than ten percent of the respondents failed to complete a particular item on any instrument. These will not be included on the tables in this report. Instead, each table will present an accurate frequency of those who responded to the items. The total number of respondents for each table will, therefore, vary.

Description of Trainees

It is clear from Table 4-2 that the MDSS contract stipulation of 1420 enrollees was satisfied since there were actually 1662 enrollees. The number of providers completing the training was 1363, eighty-two percent of the total number enrolled. The drop-out rate for home providers was 12% and for center providers, 21%. When characterizing the number of trainees reached by this project, it should be noted that many of the 299 trainees who enrolled, but did not complete training, attended more than one session. Some even attended most sessions but were unable to make up one or two missed sessions. Thus, some amount of training reached more than 1600 providers.

Place of Work. Of the 1514 trainees who completed the questionnaire at their first training session, 487 were home providers and 958 were center providers. There were 69 who did not check either category. Thus, the number of center providers trained who completed the initial survey was about 1.9 times the number of home providers. According to MDSS statistics, the parent utilization rate of centers is about 1.5 times the number of home providers used. Thus, when we compare the ratio of center to home providers who were trained to the actual utilization of care by MDSS assisted children, the ratios are similiar. It is clear that one of the important goals of this project, the enrollment of a significant number of home providers, was met. This group formerly had little access to training and, therefore, was considered a priority target for the efforts of this project.

Age. The next demographic characteristic of the trainees to be examined is that of age. The proportion of trainees in each age grouping, for home and center providers, is presented in Table 4-3.

Seventy percent of all those trained in this project were between the ages of twenty-one and forty years of age. It is interesting that the proportion of trainees over the age of fifty was almost as great as the proportion under the age of twenty-one. The very small number of home providers under the age of twenty-one is probably related to the frequency of home providers under the age of twenty-one in the

Table 4-3

Age by Type of Provider

Age	Provider				Total	
	Home		Center			
	N	%	N	%	N	%
Under 21	11	2.3	145	15.4	156	11.0
21-30	197	41.1	400	42.4	597	42.0
31-40	170	35.6	229	24.3	399	28.1
41-50	61	12.8	92	9.8	153	10.8
Over 50	39	8.2	76	8.1	115	8.1
TOTAL	478	100.0	942	100.0	1,420	100.0

Chi Square = 66.52, p <.000.

population at large. A home provider must have an established residence with adequate space and equipment for children. This proviso represents a degree of economic stability that many persons under the age of twenty-one have not yet achieved. Thus, there is no reason to believe that there was an age group of providers who were not adequately reached by training. Statistics do not currently exist that describe the age status of providers in the state of Michigan. Consequently, no base data were available for comparison with the training group.

Ethnic Background of Trainees. As with other relevant demographic characteristics, the Michigan Day Care Provider Training Project: Year One, intended that recruitment and scheduling would result in training for as wide a range of providers from various ethnic groups as possible. Serving the entire range of ethnic groups in the population was assumed to be an essential aspect of meeting local needs for training. Three factors integral to the project were designed with this goal in mind:

1. The use of a subcontractor system with an emphasis upon programming to meet local needs (such as those of a particular ethnic group).
2. The use of local advisory groups to help the subcontractors plan and monitor the training process.
3. The encouragement of subcontractors to communicate with local, established community child care groups in order to facilitate the flow of information and resources.

The ideal method of assessing the project's success in reaching various ethnic groups would be to consider the relative representation of each ethnic group in the total group of all providers in the state. Since these statistics were not available, ethnic group representation in the state's population as a whole was considered. Table 4-4 reports the representation of various ethnic groups in the groups trained and in the population of Michigan as a whole.

Ethnic groups were differently represented for home than for center trainees. The primary difference was that fewer home than center providers were from minority groups. Less than a fifth of home providers checked a category other than white, while almost a third of the center providers checked such a category.

Table 4-4

Percent of Ethnic Groups in Michigan
and By Type of Provider

Ethnic Groups	Michigan* (1975)	Provider		Total
		Home	Center	
Black Afro-American	12.2	15.9	23.8	21.1
White	85.6	80.7	69.0	72.9
Hispanic	1.4	1.2	4.6	3.5
Native American Indian	.3	.8	1.0	.9
Asian and Others	.5	1.4	1.6	1.6
TOTAL	100.0	100.0	100.0	100.0

Chi Square = 25.51, p <.000.
*Source: Michigan Department of Management and Budget

The most remarkable aspect of the information in Table 4-4 is the diversity of ethnic groups trained. A greater proportion of each minority group was trained than is found in the state's population. The fact that this project reached providers who take care of all the different kinds of children in the state demonstrates the success of the recruitment procedures used by the subcontractors as well as the positive nature of their reputations in diverse communities.

Gender of Trainees. Although almost all of the providers trained were women, about four percent were men. These fifty-two men were primarily center providers; only nine worked as home providers. In at least a few cases, the male home trainees worked with their wives to provide home care and attended training together. Although there are no data regarding the gender of the providers across the state, it is believed that the training reached a representative proportion of males.

Location of Trainees' Centers and Homes. An important goal of the current project was to utilize subcontractors across the state to provide relevant training effectively to providers from diverse areas. Map 1 demonstrates the location of the fifty-seven counties to which subcontractors directed their efforts (see Appendix C for detailed maps). The project aimed to meet local needs in a variety of population areas, rural as well as urban. Examination of Table 4-5 reveals that the areas in which the trainees' homes and centers were located were indeed diverse. Although the smallest percentage of all providers worked in a suburban center or home, each of the five categories contained a sizeable number of trainees. The largest group of home trainees provided child care in rural or small town areas, while the largest group of center trainees provided care in centers located in medium-sized cities. Although almost a fifth of the trainee homes were located in a suburban area, less than a tenth of the trainee centers were located in a suburb. Disproportionate enrollments of center and home providers were therefore found for three of the five areas: rural or small town, medium-sized city, and suburb. As expected, center providers were less likely to work in a rural area or in a suburb than were home providers, due to lower population density in such areas.

MAP 1

MICHIGAN COUNTIES IN WHICH TRAINING WAS OFFERED (PROJECT YEAR ONE)

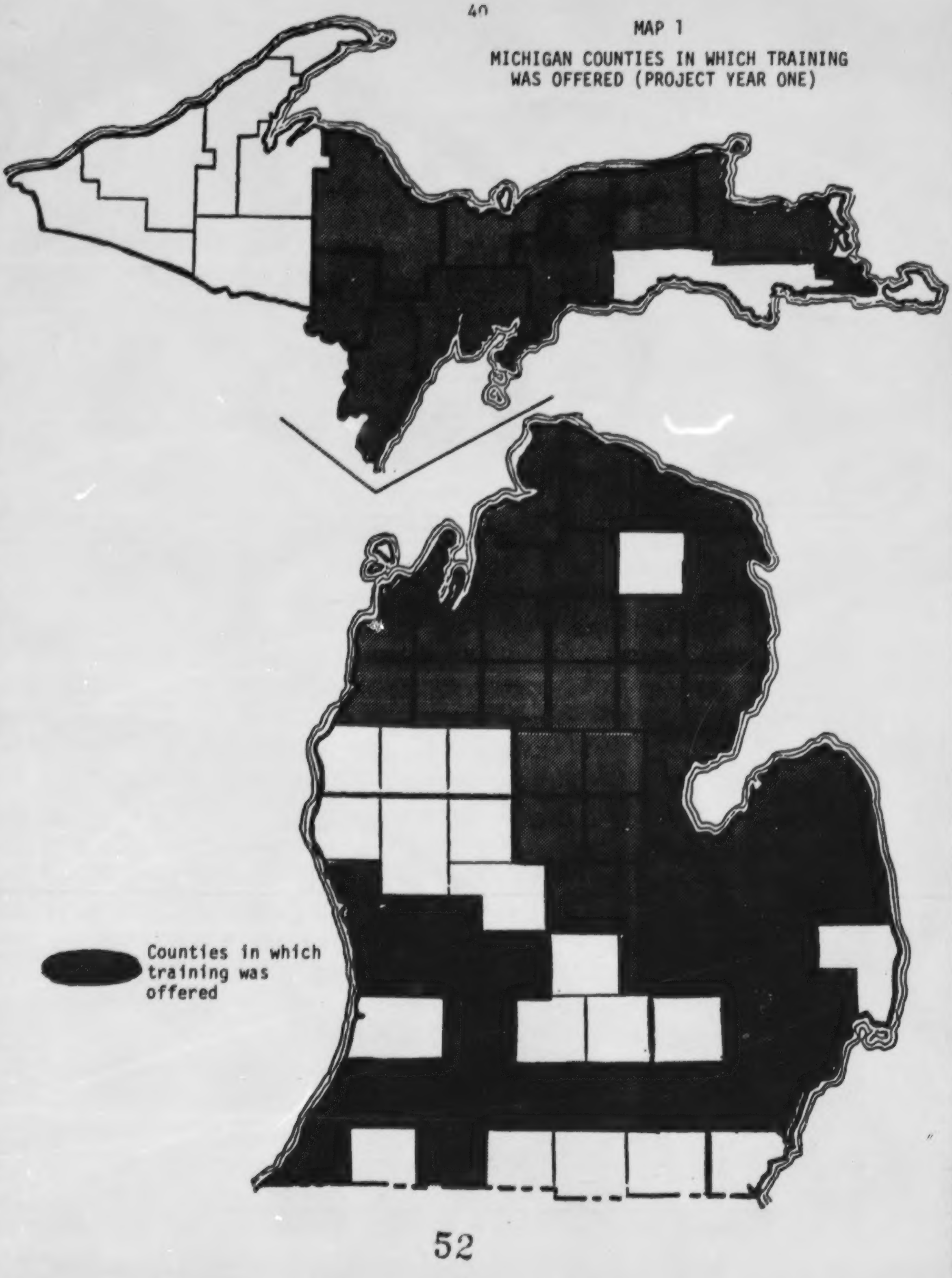
● Counties in which training was offered

Table 4-5

Size of City By Type of Provider[1]

Size of City*	Provider				Total	
	Home		Center			
	N	%	N	%	N	%
Rural or small town	153	32.3	186	20.0	339	24.1
Small city	68	14.3	168	18.1	236	16.8
Medium-sized city	90	19.0	320	34.4	410	29.2
Suburb	92	19.4	81	8.7	173	12.3
Large city	71	15.0	175	18.8	246	17.5
TOTAL	474	100.0	930	100.0	1,404	100.0

Chi Square = 79.57, p <.000.

* These five categories were self-defined by the participants.

[1] 58 persons did not answer this question.

Educational Background. As this project was a demonstration project, data were not available at the onset to describe the potential trainees in detail. It was especially important to gauge the educational level of the trainees accurately so that materials would represent the appropriate level of content and type of presentation. This variable was also of concern to the evaluation staff during the time that instruments were being designed to assess training needs, perceptions, and outcomes. It was assumed that the trainees would include a wide range of past educational preparation, from persons with an elementary school education to college graduates. Table 4-6 reports the highest educational levels completed by home and center providers. Almost one half of all trainees had no education beyond the high school level. Another thirty percent had some college classes but no degree. About twenty-one percent had completed a type of college degree.

Interesting differences emerged between the home and center providers on educational level. More center providers (26%) had completed a type of college degree than had the home providers (12%). While the highest level of education completed was a high school degree for most of the home providers (60%), it was the highest degree for fewer of the center providers (42%). Home providers had a lower educational background than the center providers trained in this project.

Table 4-6

Educational Level By Type of Provider

Highest Educational Level Completed	Provider				Total	
	Home		Center			
	N	%	N	%	N	%
Elementary School	12	2.5	22	2.3	34	2.4
Some High School	78	16.2	107	11.3	185	13.0
H.S. Diploma or G.E.D	198	41.2	272	28.8	470	33.0
Some College	136	28.3	297	31.6	433	30.4
Assoc. of Arts	15	3.1	51	5.4	66	4.6
Bachelor's Degree	24	5.0	97	10.3	121	8.5
Some M.A. Credits	14	2.9	76	8.1	90	6.3
Master's Degree	4	.8	21	2.2	25	1.8
TOTAL	481	100.0	943	100.0	1,424	100.0

Chi Square = 52.60, p<.000.

It is surprising that more than half of all those persons trained had some training at the college level. Perhaps this is due to the fact that most subcontractors offered some type of college credit for the training received. Such an offer may have convinced providers who already had some college credit that the sessions would be taught at a level congruent with their background. If college credit had not been offered, they might have assumed that the training would be too elementary for their needs. It is also true that this was a pilot program: the training was new and experimental. Some providers with lower levels of past education may have been hesitant to try a new training program. Later training sessions may well reach more of these providers who by then may feel more comfortable enrolling in a proven program. At any rate, it is understandable if the training in Year One attracted a disproportionate number of persons with higher educational levels for the reasons mentioned above. In future training, recruitment efforts should be directed toward persons with lower educational backgrounds.

Ironically, a major constraint in the development of evaluation instruments, especially the knowledge measurement, was concern over the literacy rate of potential trainees. The master contractor, as well as the subcontractors, discussed this frequently and at great length. Yet only fifteen percent of all trainees had not received their high school diploma. Despite the large percentage of trainees with a high school diploma or more, trainers reported that some trainees were functionally illiterate. There is no indication that this interfered with training; the trainers adapted to their "students". This is one of the advantages of a flexible central organization with local design and implementation. On the other hand, the evaluation instruments, which were centralized, were designed so that an oral presentation could be made.

Language was also a problem for some groups. One subcontractor sought out the Hispanic population for training. A bilingual facilitator was hired who assumed responsibility for two ETU's. Many of the resource persons for these two groups also spoke Spanish. Some subcontractors have requested that all curriculum materials for trainees and evaluation instruments be bilingual in the future.

It appears that trainees who had literacy problems and/or problems with English were treated sensitively by the trainers. One trainee who could not read and write at all was considered the most responsive trainee in the group by the trainer. This trainee had many ideas to share with the others and seemed to gain a great deal from the program.

The project's goal of meeting local needs by providing convenient sites and schedules meant that no screening process nor any method of trainee assignment to ETU's was utilized. All persons requesting training in a given area at a given time were usually trained together. It was therefore probable that any particular ETU contained trainees with widely different educational backgrounds. Programming for such heterogenous groups relied heavily upon the expertise and interpersonal skills of the trainer.

The disparate educational backgrounds of the providers trained verifies the importance of the CUS/WSU model that encouraged the local subcontractors to adjust their training curricula and programming to match the needs of their particular trainees. Any "packaged" curricula for provider training in heterogeneous groups should probably be seen as a guide rather than as a mandate. The success of training programs for providers that utilize such a guide would depend heavily upon the trainer's skill in adapting it to fit the needs of the particular group of trainees in an ETU.

Child Care Training. In addition, to or as part of their general education, many providers had specific training in child care. The initial survey asked them about their experiences in a variety of possible child care training situations. Table 4-7 presents the prior training which these providers reported.

The largest differences between the center and home providers occurred for college courses in child care and for child care conferences or workshops. In both cases, more center providers had received such training than had home providers. This is not surprising since more center than home providers have some college education (as assessed by the educational background question). Further, lower attendance at conferences and workshops by home than center providers

Table 4-7
Previous Child Care Training*

Previous Child Care Training	Provider (Percent)		Total
	Home	Center	
High school courses	41.0	40.0	40.3
College courses	21.0	46.0	37.6
Conferences or workshops	30.0	54.2	46.0
Child Development Certification (CDA) Training	3.3	3.0	3.1
Other	15.0	8.8	10.9
	(N=480)	(N=943)	(N=1423)

* Sum is greater than 100% because of multiple responses.

may result from the relative isolation and longer work hours of the home providers. Since center providers work together, they can more easily transmit information about conferences as well as make group arrangements for travel, substitutes for child care in the center, and so forth, than can home providers. According to survey responses, over half of the home trainees cared for children more than 40 hours per week, while less than five percent of the center providers worked longer than a 40-hour week. Another contributing factor may have been the home provider's view of his or her job. Fewer home than center providers many have viewed their job as a profession that demands up-to-date inservice training.

Reasons for Training Enrollment. Trainees were asked on the Caregiver Information Survey to check from a list of ten reasons their own two most important reasons for enrolling in training. Their responses are shown in Table 4-8. The answer most frequently chosen was, "I want to learn more about children and their development". Almost two thirds of all the trainees chose this as one of their two responses. More than sixty percent of all trainees chose the response that training would help them "to do a better job as a caregiver". All other responses were infrequently chosen. The least popular response, chosen by less than one percent of the trainees was, "I expect to be paid more after this training." It was very important to only a few providers to meet and talk with other providers or to obtain college credit. Thus, the largest proportion of these providers expressed a sense of commitment to their own education and performance as child care professionals by checking one or both of the two most frequently chosen responses discussed above.

Summary

Despite the short time available to the subcontractors for recruitment and planning in this project, all project goals related to recruitment were satisfied. The number of enrollees, the geographic

Table 4-8

Two Most Important Reasons For Attending Training

Reasons	Percent* of Trainees
The director of my center asked me or told me to come.	11.0
I want to meet and talk with other child care providers.	17.2
I want to learn more about children and their development.	65.9
The workshops will help me to do a better job as a caregiver.	61.0
I am curious about what kind of training will be given.	10.0
I want to obtain college credit or other training credit.	14.0
I expect to be paid more after this training.	.9
I expect that I may be able to get a better job in the future due to this training.	10.4
Other caregivers that I know encouraged me to come.	1.3
I have a specific problem in my center that I expect the training to help me with.	2.8
No answer given.	5.5
	(N=1514)

* Sum is greater than 100.0% since each trainee gave two responses.

areas served, the representativeness of the groups served, and the number of home providers trained all met the standards of the MDSS contract. The one recommendation that should be made with regard to the population served is that, in the future, recruiting procedures be developed to attract more persons with lower educational backgrounds.

Chapter 5
Process - The Trainers

It would be impossible to understand the training process without knowing about the trainers. This chapter, then, describes the persons who did the actual training. In four out of five ETU's, one trainer did most or all of the training while in the remaining ETU's a variety of persons actually conducted the training. Since, in the latter approach, the trainer kept changing, a "facilitator" was assigned to the ETU. This person attended all sessions to provide continuity, make necessary arrangements, assume responsibility for materials and so forth. Of course, even where the ETU had a consistent trainer, outside resource persons were sometimes invited to speak, but the trainer was responsible and, indeed, did most of the training. The following sections refer only to the consistent trainers.

Educational Level

The educational levels for the consistent trainers are presented in Table 5-1. Less than ten percent of the trainers might be considered

Table 5-1
Educational Level of the Trainers

Highest Degree Completed	Number	Further Training
No degree or diploma	1	
High school diploma	2	Both have earned some college credit.
Bachelor's degree	11	Five have earned some graduate credits.
Master's degree	20	Two are doctoral students.
Ph.D. degree	3	
Unknown	1	
TOTAL	38*	

* Information was unavailable for four trainers.

paraprofessionals. More than ninety percent of the trainers in this project had college degrees; seventy-four percent had some graduate training. Futhermore, the persons responsible for direct contact with and training of the providers were, for the most part, persons with an academic background in a field related to the education of children. Of these thirty-five trainers with college degrees, twenty had degrees in education, many in early childhood education. Twelve had degrees in human development or home economics programs. There were only three trainers with degrees in fields not directly related to education or child development.

Experience in Adult Education

Almost half of the trainers had college teaching experience. Sixteen percent had not taught in college but had adult teaching experience in other settings, such as teaching in high school, in a community center or organization, in an adult training project, or in a church or temple. Altogether, therefore, almost two thirds of the trainers had experience in teaching or training adults in various settings.

Experience as a Day Care Provider

Thirty-three (87%) of these trainers had experience as day care home or day care center staff members. This very large percentage of trainers who actually had experience in the delivery of child care to families may have resulted from the choice of subcontractors with extensive connections to the child care communities in their own locales. These subcontractors then recruited experienced persons whom they knew from that community. The coincidence of college education with child care experience in this group of trainers is worth noting. It appears that an adequate pool of professionals exists in Michigan with both the academic competence and the applied skills to carry out training programs for day care providers. The perceptions of the CUS/WSU field representatives, who made visits throughout the project to training sessions, was that trainers with some professional experience in child care settings were able to add an important dimension to training.

Participation in Early Childhood Organizations

Another relevant aspect of the trainers' backgrounds was the extent to which they had been involved in community organizations that promote child development and family issues such as 4-C's, the Family Day Care Association, the Association for the Education of Young Children, and the Michigan Council on Family Relations. More than sixty percent of these trainers were members of such an organization. Of those with membership, two thirds had been national or regional officers in such groups.

Thus, many of these trainers were actively involved in the broader aspects of their profession. Such organizations promote professional identity, education and/or advocacy. It would appear, as discussed later in this report, that having such trainers may have reinforced the positive identity of the trainees in these same areas.

In summary, the trainers for this project seemed especially well suited by experience, academic background, and professional involvement to the complex tasks of training implementation for day care providers.

Training Schedules

Although most trainers were responsible for only one or two ETU's during the summer training phase of this project, some taught three or more. The number of ETU's for which each of the seventy-eight consistent trainers was responsible is presented in Table 5-2 below. The ten trainers who each taught three or more ETU's were responsible for a sum of forty of the total number of ETU's taught by a consistent trainer. The remaining thirty-eight ETU's were taught by thirty-two different trainers. It is clear that the ten trainers with heavy training schedules contributed disproportionately to training.

This also raises an issue regarding the evaluation. The trainers completed two instruments: (1) the Trainer Perception Form (filled out before and after training for each ETU) and (2) the Trainer Training Session Description Form (filled out after each session). Thus, some trainers affect the data more than others. On the other hand, the data are representative of the training for each ETU.

Table 5-2

Number of ETU's
Taught by the Trainers

Number Taught	Number of Trainers	Total
One ETU	26	26
Two ETU's	6	12
Three ETU's	3	9
Four ETU's	5	20
Five ETU's	1	5
Six ETU's	1	6
TOTAL	42	78

There are, of course, certain advantages to having the same trainer take responsibility for multiple ETU's. These people have a chance to learn from their own experience and improve their presentations.

With regard to the schedule, one further item should be mentioned. Many of these trainers and facilitators spent an inordinate amount of time on this training project. They along with the subcontractors were involved in the strong desire to make this first year a success--the motivation that often comes with a new program. Along with this, as indicated by their involvement in this field, these trainers have a strong commitment to the child care field. In looking forward to future training, one cannot, nor should not, anticipate the same quantity of working hours on the part of a large number of the trainers.

Relationship with Subcontractors

There was great variation in the autonomy of trainers. Some subcontractors had regular meetings with their trainers and maintained rigid control over class content; others allowed trainers great autonomy and had few meetings. To some degree this was based on management style and perceived trainer competency; however, it was also based on necessity. In urban areas like Detroit the trainers and training sites were highly concentrated. It was relatively easy for the subcontractor to meet with the trainers. In other areas of the state, the trainer and training site was a few hours away from the subcontractor.

Summary

Subcontractors were able to select a number of trainers with an educational level and prior experience quite relevant to this training program. Further, many had an unusually high level of commitment which appeared to be transmitted to the trainees and, on the part of some trainers, was shown in the number of hours they spent on the program.

Chapter 6
Process - The Shape of Training

Having some descriptions of the persons trained (the providers) and the trainers, it becomes appropriate at this point to discuss the training itself. This chapter, then, describes the shape of training including format and topics as well as the number and length of training sessions.

The individuality of design and training needs is perhaps indicated more directly in attempting to describe "the training" than in any other portion of this project. Indeed, every possible format, length, and type of training session were utilized. If no model training session can be described, it would be satisfying to be able to indicate that at least one or two types emerged from the myriad of training session types to be more functional than the others. This was not the case. Needs and situations varied greatly, creating just as many satisfactory training session types.

It would appear, therefore, that a description of these variations along with their functional and dysfunctional aspects is most appropriate. To begin with, CUS/WSU set few constraints on the training modes. As indicated earlier, it was the basic philosophy of this project that local groups could best determine local training needs as contrasted with one modality by an imposed singular agency. CUS/WSU, therefore, prescribed that each training component (ETU) should include a minimum of twenty training hours and that curriculum should be selected from the total competency topics. No one was expected to cover all of them. Within this, the training was to take the form determined most appropriate by the local training institutions.

No single model worked best. Obviously, where providers are geographically spread, it is very inefficient for a trainer to travel two hours each way for a two hour training session each week for eight weeks. On the other hand, it is difficult to have a five hour session in the evening. Thus, there were built-in constraints in many situations. One thing is certain; different modes were attempted in order to find the best fit for each situation. A summary of the time frame in which training took place is presented in Table 6-1. As indicated, most of the training was during the evening exclusively or in combination with other times.

Table 6-1
Meeting Time for ETU's*

Number of ETU's	Time Frame
30	Evening sessions
17	Evenings and Saturday sessions
13	Afternoon sessions
11	Morning sessions
6	During naptime at day care centers
5	Saturday sessions
5	10 hours of cable television and 10 hours of afternoon sessions
4	Afternoon and evening sessions
2	3 all-day sessions during the week
1	2 all-day Saturday sessions, one all-day session during the week, and a weekday evening session
1	Afternoons on Friday and Saturday
95	

*Inclusion in each of these categories is approximated because of unrecorded changes.
One subcontractor utilized all-day Saturday in combination with other times. However, it was optional for some and required for others. Therefore, the Saturday session is not included in this table.

Format

With regard to format, some training was in the standard classroom style. Providers came to a central location two hours a week for ten weeks. On the other hand, other ETU's ran for two whole days, similar to weekend workshops. Some used a combination of structures. In essence, about one fourth of the individual sessions lasted four hours or more. The majority used a model with shorter but more frequent sessions. In fact, of those sessions that ran less than four hours (73%), over half, ran less than 2 1/2 hours, or at least changed format and speaker in that time period.

Subcontractors were encouraged to use a format that best fit their providers and topics. Some, therefore, used only a lecture format, others combined formats. Some used exactly the same format across all sessions and all ETU's. The use of the same format had certain advantages in that there was more control and accountability by the subcontractor as well as advantages gained by the experience of repetition. On the other hand, some varied the format depending upon the topic or group (for different ETU's). This also had advantages in that it tended to adapt more to individual needs as well as to fit topics more precisely. As indicated by Table 6-2, about three out of every five sessions were in a lecture format (59%); obviously, many of

Table 6-2

Predominant Format of Individual Training Sessions

Predominant Format	Training Sessions* (percent)
Lecture or talk by trainer	59%
Participant discussion - entire group	55
Special outside speakers	23
Making toys, learning material or food	15
Film or videotape	14
Participant discussion - small groups	8
Observing children	6
Role playing (as child or teachers)	5
Individual consultation with trainee	1 (N=94)

* Sum is greater than 100% because of multiple responses.

these also included a great deal of discussion by the participants as an entire group. In fact, group discussion was listed in over half the total sessions as a predominate format.

CUS/WSU encouraged the subcontractor to utilize outside speakers as a means of acquainting participants with community resources. Almost one fourth of the sessions included an outside speaker. Of course, use of outside speakers was not evenly distributed across ETU's or subcontractors; some subcontractors never used this format, others used it quite extensively with great success. In fact, other data indicate that 39% of the ETU's had no outside speakers. This may have been due to lack of knowledge about resources in a few cases, or to limited time for speaker arrangements in those ETU's that started early in the summer. In any case, a greater effort will be necessary in the future if one major purpose of the training is to introduce providers to local resource people.

It is interesting to note that the less structured formats were not used very often. This includes role playing, child observation, and small group discussion. The latter, small group participation, was probably unnecessary in many sessions because the total number of providers in the class was rather small, and their participation intense enough, so that it was unnecessary to break into small groups. Also it should be noted that there were very few "hands-on" activities, such as making toys or food (15%); although this too was encouraged.

There is some indication that the less structured formats were used infrequently because of the newness of the project and the very tight time schedule. That is, it takes more planning and coordination to observe children or make things; it also takes a knowledge of the participants. One would anticipate that future training would include more planning time, specific suggestions from the master contractor, as well as subcontractor, and ability to build on prior experience. These elements should result in greater experimentation with classroom format.

Course Content

The trainers were asked to indicate which of the fifteen competency topics were major ones for each training session. In many cases, more than one topic was covered within a single session. This was true in the shorter sessions as well as the longer ones. Table 6-3 indicates the frequency with which various competency topics were addressed. The first column indicates the percent of ETU's which never addressed a specific topic. For example, six percent of the ETU's never covered the topic of human growth and development; twenty-nine percent never discussed health; etc. The next column indicates the percent of ETU's in which half or less of the training time was spent on a topic while the last column enumerates the percent of those ETU's in which more than half the time was spent on the specific topic; for example, twenty-two percent of the ETU's spent over half of their time on normal growth and development; none concentrated this much time on health related topics; and so forth.

Essentially, the table indicates that the training was rarely concentrated on any one or two topics to the exclusion of the others. As might be expected, the most concentrated topic was that of normal growth and development. Of course, this is such a broad topic (or at least a broad title) that it is difficult to know exactly what was included without asking for overbearing detail or being observers at every training session. On the other hand, there were a few topics which were ignored in a large proportion of ETU's. One half (55%) of the ETU's did not discuss "confidentiality", the privacy of provider records and information. Two out of every five ETU's ignored legal issues. Although in some cases, topics were ignored because the subcontractor believed trainees already had sufficient information, in most situations topics were not covered because of insufficient time. This was substantiated by other comments. It may also be true that some of these topics were perceived as requiring a specialized knowledge which the trainers did not possess. This latter constraint can be alleviated by more extensive curriculum resources.

Table 6-3

Percent of ETU's That Devoted Various Proportions of Time to Each Compentency Topic

Competency Topic	Proportion of ETU Training Time			
	None	1-50%	Over 50%	Total (N=94)
1. Human growth and development	6%	72%	22%	100%
2. Health	29	71	0	100
3. Nutrition	32	63	5	100
4. Safety	27	69	4	100
5. Education process	36	55	9	100
6. Play	3	87	10	100
7. Discipline	5	85	10	100
8. Physical space	27	71	2	100
9. Programming	23	72	5	100
10. Staff relations	32	66	2	100
11. Curriculum content	31	57	12	100
12. Working with parents	27	68	5	100
13. Confidentiality	55	45	0	100
14. Legal issues	42	57	1	100
15. Understanding self	30	65	5	100
16. Other specific subjects	40	58	2	100

In essence, it is evident that training time in the individual ETU's was spent on a number of topics with none of them taking an especially large portion of time.

Unfortunately, the data could not be analyzed by type of trainee. Two out of every three ETU's contained both home and center providers so that the data were not easily examined for these groups separately. This will, however, be part of future analysis.

Although not indicated in Table 6-3, it is true that about fourteen percent of the individual sessions covered items not included in the competency list. No particular substantive area was consistently named; there was great variation. One can conclude, therefore, that the fifteen competency topics, as enumerated by the master contractor, covered those items which trainers agreed should be taught. There were, however, two substantive topics which some subcontractors believed to be important. One was the topic of administration and management. Title XX monies are prohibited for use in management training of day care center administrators. However, some center directors were involved in the training and wanted this information. Furthermore, the home providers wanted management information appropriate to their situations; they wanted to know more about liabilities, small business resources, tax issues, and so forth.

Another topic about which some subcontractors felt strongly was related to the concept of professionalism. That is, there was an interest in understanding what professional groups have to offer and, beyond that, strategies for political advocacy to foster their interests. Certainly, these topics are indications of growing professional identity, an attitude usually associated with increased interest and competency.

In essence, most ETU's included a selection of competency topics rather than the total fifteen. This selectivity had been expected considering the fact that the ETU was only twenty hours long. There was not time to cover all topics, and many providers did not need information in every area. It would appear that some of the basic and broader issues such as human development, play and discipline were covered in detail by most trainers. Thus, the priorities of the individual subcontractors, for the most part, were the same as those of the master contractor.

Structure

The following represent important aspects of the various training models utilized in different ETU's. Sometimes a subcontractor followed a model consistently and sometimes there was variation of a particular aspect of training among the different ETU's presented by a given subcontractor.

On-site Training. As indicated elsewhere, the master contractor wanted the training to incorporate formats other than standard classroom lecture. CUS/WSU was particularly concerned about this issue since almost all subcontractors were teaching institutions who might rely heavily on standard format. Furthermore, the on-site training has certain advantages. A center in operation provides an opportunity to model, discuss, and evaluate observations of and interactions with other staff members and children. If the center is not in operation, the arrangement of physical space and provision of various kinds of equipment can be analyzed in a concrete sense. The physical environment can be rearranged to illustrate various points. Multiple uses of equipment can be demonstrated as well as accident prevention.

For these reasons, on-site training was encouraged. Indeed, this was successful; all but one subcontractor had at least one of their training sessions on-site at a center or provider's home. Some creative measures were used to bring providers to family day care homes, as well as centers, and the impact of this type of exchange appeared to be quite positive.

It should be noted that there are disadvantages to on-site training when adequate adult seating is not available. Trainees had legitimate complaints concerning the discomfort of sitting in child-size chairs at low tables during some training sessions. Often the on-site training took place when there were no children present. Nevertheless, it was believed by CUS/WSU and some subcontractors that being in a child care center (or home) lent a constructive atmosphere as well as allowing for the use of certain materials not available in the standard classroom.

Some subcontractors had sessions for the center providers scheduled during the children's naptime. The advantage of this timing was that providers could have their training during their working hours and without traveling. On the other hand, this plan had some disadvantages. The primary one was that training now substituted for the provider's only break and rest period during the day.

Although the master contractor had hoped that some training could take place when children were present, most subcontractors did not find this feasible. As indicated elsewhere, only seventeen percent of the ETU's included observing children at all. The logistics were considered too difficult both with regard to time of day and simply having that many people in a room. Those who did on-site training with children present used some innovative measures to accomplish this. The use of the foster grandparents program in one family day care home is discussed elsewhere.

Certainly, it can be said that the master contractor achieved its aim of on-site training which was a meaningful format. At the same time, being in the classroom feels more like school and therefore allows the providers to feel that they have been successful in school -- one of the major spinoffs of this training. Thus, probably a combination of sites is the optimal design.

Provisions of Child Care. Several ETU's were arranged so that child care was available during the session. Sometimes the care was for the trainees' biological children and sometimes it was for children in the care of home trainees. Such care was made available to facilitate trainee attendance and to provide real children for observation and interaction projects with the trainees. The primary disadvantage lay in the fact that it was almost never possible to predict how many children would attend a session. The child care area was almost always either understaffed or overstaffed. Despite this problem, some subcontractors remained committed to the provision of child care as a service to the trainees. In one ETU with home providers, however, the trainer recommended that afternoon, weekday sessions with child care be discontinued. In this ETU, transportation was provided for the home providers and the children in their care. The providers were not pleased with the amount of disruption caused by transporting their children back and forth to the training site. In addition, they sometimes were distracted from training by their need to check up on a child who had come with them. Based on these reactions, their trainer felt that Saturday training sessions without child care would better meet their needs.

Field Trips to Centers or Family Day Care Homes. Some ETU's were based upon trainer visits to the trainee's place of work. In other cases, a group of trainees were scheduled to visit day care centers or homes in the community. These observations were later discussed in training sessions. One subcontractor who utilized several field trips evaluated them as worthwhile and well-received by the trainees. The home trainees were especially positive about the trainer visiting them in their own home. In this visit, it was possible to discuss details concerning the needs of the particular children she served, the arrangement of the physical space indoors and outdoors, and various safety aspects of the home. This session was truly tailor-made to speak to the unique role played by that particular provider in her particular home. The scheduling demands of such visits presented problems, however. It also appeared that the trainers who provided such experiences spent long hours in their implementation. Transportation and scheduling time were obviously involved. In addition, when the provider had many questions or truly needed support in some area, such visits were lengthy.

Choice of Make-up Sessions. In some ETU's an extra last session was provided to serve as a make-up session for those who had missed one. In other ETU's, the trainer distributed a schedule of another ETU nearby so that trainees could switch ETU's to make up missed sessions. Neither of these options was optimal since a topic might be covered, in a general make-up, or in a switched session, on which the trainee had already been trained. In addition, switching ETU's at will was probably not as helpful to the trainee as a consistent experience with the same training group and trainer. One creative solution to the problem of make-ups was provided by one subcontractor. For several ETU's, three options were offered as make-ups which were self-scheduled by the trainees. The following options were offered: (1) a film festival of films on child care and child development topics, (2) a supervised observation in a model child care center, and (3) a demonstration of appropriate activities and toys for infants and toddlers. None of these experiences had been presented in the regular sessions, yet all were relevant training activities. Feedback indicated that trainees were very favorable toward all three options. Trainees who observed in a model child care center said that they had been skeptical that an "ideal" setting would work and yet here they saw that it does.

Out of Class Assignments. One subcontractor required all trainees to complete the following three activities: (1) observe one child in a child care center and write up the observation, (2) complete reading assignments from a specified textbook, and (3) record five activities each week that they did with the children in their care. This is an appropriate way to obtain more trainee involvement without taking up additional class time. It might also be easily used for make-up work. For those with a literacy problem, this could be adapted to an oral seminar situation. This, however, does focus on one potential problem mentioned elsewhere. Training must be designed with the expectation of sufficient out-of-class time for trainers.

Observations and Interactions with Children in Care During Training Sessions. In some centers, the entire staff or a large percentage of them was trained together. One subcontractor used a pair of trainers to accomplish on-site training of an entire center's staff. The staff was divided into two groups. While one group participated in the day care rooms with a trainer acting as a model caregiver, the other group met in a discussion-lecture situation with the other trainer. At a given time, the groups switched so that all trainees had both components of training at each session. Very positive trainee responses were reported by the subcontractor for this type of training structure.

In summary, each subcontractor designed the shape of their ETU's to fit their needs. As expected in a first year program a few of the choices of format, content, and structures turned out to have unexpected disadvantages; most however, worked well. Future training will, of course, be able to take advantage of these experiences through an exchange of information between subcontractors and planning with the master contractor.

Chapter 7

Outcomes - The Trainers' Perceptions

An important element in the training situation is the attitude of trainers. Certainly their perception of the training is crucial to understanding the process which took place. This chapter, then, will discuss their expected and consequent attitutes regarding strengths and barriers to the program's success; their level of satisfaction; and their evaluation of each session.

Strengths and Barriers to Training

People tend to behave on the basis of their expectations; they, further, tend to modify their behavior as a result of the degree to which these expectations (positive or negative) are met. Thus, it was important to measure some aspects of the trainers' expectations before the first session of the ETU and again after the last session of that ETU. On both occasions, they were given eleven statements regarding barriers to the success of the program and eleven statements concerning program strengths which they scored on a five-point scale (see Appendix A, Trainer Perception Survey). The mean scores of the pre and post measures are presented in Table 7-1. Perception of training strengths was not influenced by the experience of training. A relatively high

Table 7-1

Trainers' Perceptions of Training Strengths and Barriers: Summary Scores, Pre and Post

Perception	Mean Score*		t value	Probability
	Pre	Post		
Strengths	3.85	3.80	1.01	N.S.
Barriers	2.27	1.81	5.57	.000

* Scores ranged from 1=not at all likely to 5=extremely likely.

score was obtained, both before and after training, indicating that the trainer's own background, as well as the resources available to them, were viewed as helpful to the training process.

The items in the strengths section perceived as most helpful were those related to the trainers' own education, experience and skill (see Table 7-2). Two items that were not personal characteristics but that were under their own control, resource materials and enthusiasm derived from group discussion, were also seen as likely to be very helpful. The items expected to be least helpful were those over which the trainers had least control, i.e., support provided by the subcontractor, support provided by the master contractor, the training site, and the concentrated time period for training. These perceptions of training strengths were remarkably stable from the pre to the post measure.

A different picture emerges when one examines the findings for the trainers' perceptions of barriers to training on the pre and post measures. On the pre measure, the trainers saw some small likelihood that the items listed would prove to be barriers to training. By the conclusion of their ETU's, however, they felt that these items had proved even less problematic than they had estimated in their original assessments. There was a significant difference between the mean scores, pre and post, for perceived barriers.

The fact that the trainers reported that they actually experienced fewer training barriers than they had anticipated indicates the positive nature of the teaching experience for the trainers. They found less "burn-out" among the trainees, less rejection of suggestions during training, less trainee mistrust and hostility, and even less difficulty with trainees who lacked reading and writing skills, than they had anticipated. The pre-post differences in the mean scores for perceived barriers seems especially striking since the trainers' expectations of barriers was relatively low initially. From the trainers' viewpoint, it would appear that the experience of conducting training sessions for these particular providers convinced them even further of the feasibility of such training.

Table 7-2
Trainers' Perceptions of Training Strengths and Barriers:
Individual Scores, Pre and Post

Strengths	Pre		Post	
	Mean	SD	Mean	SD
Education	4.57	.61	4.51	.64
Day care experience	4.47	.76	4.43	.71
Local contacts	3.89	1.02	3.92	1.07
Resource materials	4.13	.66	4.14	.76
Group discussion	4.32	.69	4.35	.72
Interpersonal skill	4.21	.75	4.24	.69
Subcontractor support	3.94	.92	3.70	1.01
Room condition	3.15	.99	3.27	.95
Parental experience	4.29	.73	4.41	.59
CUS/WSU support	2.84	.97	2.41	1.01
Time frame	2.97	1.06	2.76	1.12
	(N=55)		(N=58)	

Barriers	Pre		Post	
	Mean	SD	Mean	SD
Inadequate resources	2.03	1.05	1.85	.88
Inappropriate resources	2.24	.98	2.03	.96
Attitudinal differences	2.11	.83	1.87	.93
Participant misinformation	2.31	.74	2.00	.91
Participant burn-out	2.54	.98	1.95	.90
Lack of effort	2.67	1.00	2.03	.85
Lack of funds	2.78	1.10	2.13	.88
Mistrust among participants	1.94	.91	1.33	.65
Trainer/participant mistrust	1.84	.81	1.31	.65
Hostility of individuals	1.98	.79	1.40	.78
Participant literacy	2.40	1.04	1.94	1.25
	(N=62)		(N=59)	

Both before and after training, the item that was perceived to be the greatest training barrier was the possibility that trainees might reject suggestions "due to lack of money in their centers or homes to implement them". The item that was seen as least problematic, both before and after training, was the training barrier, "mistrust between trainer and participant". These trainers felt comfortable that they could and did develop trusting interactions with the trainees.

It is one thing to feel very positive in anticipation of such an experience; it is quite another to end such a training experience with even more positive feeling. This is especially remarkable considering the speed with which the training was put together. Of course, it may well be that this positive attitude was affected by the experimental nature of this project which may have produced a Hawthorne effect. (Roethlisberger and Dickson, 1939). This effect refers to the fact that persons being studied sometime appear to modify their behavior or reactions as a result of feeling that they are "in the spotlight". If the trainers had attempted to show their best behavior as a result of knowing that they were being studied, one would expect both the strengths and the barriers scores to reflect such a tendency. The fact that only the barriers score improved lends credibility to the interpretation that there was a valid change in trainer perceptions of barriers during the course of presenting twenty hours of training.

Trainer Session Perceptions

In the expectation that trainers' attitudes might be related to what was happening in the individual training sessions, they were asked to evaluate each training session at its conclusion (see Appendix A, Trainer Training Session Description Form). First, they were asked to rate the success of the training session on a four point scale which is indicated in Table 7-3. Obviously, the trainers believed that the sessions were successful. In fact, slightly more than one-third rated the individual sessions with as high a ranking as the scale allowed.

Table 7-3

Rating of Training Session By Trainer

Rating	Percent
Very unsuccessful	2.2%
Unsuccessful	1.3
Successful	59.4
Very successful	37.1
TOTAL	100.0
MEAN	3.3 (N=537)

Further insight into trainer feelings about the training sessions are obtained from the two unstructured questions asking them what they felt could be improved and what they liked best about the training session.

First, it should be noted that for forty-eight percent of the training sessions, the trainers did not give any comment regarding improvements; the same was true for twenty-one percent of the training sessions regarding what they liked best. It must be remembered that these were self-administered questionnaires and that often the same person responded numerous times, once for each training session. Probably some thought it was foolish to keep repeating the same response if either what they liked best or what needed improvement remained the same. Further, people tend to leave the response blank if they have nothing to say. This would explain why the number who left the improvement question blank was much higher than the number who left the question regarding which they liked best blank. A substantial number of people did not think it needed improvement.

Of those who made suggestions, as can be seen in Table 7-4, the primary method of improvement was to allow more time for the session (26%). This, in fact, can be viewed as a positive statement; at least the sessions were of a caliber that the trainer wanted them extended.

An attempt was made to group together those items which might be related to planning, either by the subcontractor or CUS/WSU, as compared to those items which related to immediate facilities such as room condition or problems with resources (e.g. broken projector). There simply didn't appear to be any overriding area suggested for improvement. This seems particularly surprising given the condensed lead-time. On the other hand, it is just such an auspicious beginning to an experimental project which often results in a high level of esprit de corps and perhaps somewhat of a Hawthorne effect. One cannot be so certain of such a level of tolerance if this training program were established.

Table 7-4

Trainers' Suggested Improvements
for Training Sessions

Categories of Comments	Percent*
Need more time	26%
Organization/planning of session and materials	14
Inadequate resources	13
Condition of the room	10
Trainees' lack of motivation, tired, etc.	7
Trainees' lack of discussion	6
Lack of program coordination	5
Disapproval of a specific format (e.g., film)	5
Disapproval of a specific topic	3
More discussion time	3
Specific problems of set-up for class	3
Evaluation forms	3
Miscellaneous	10
	(N=312)**

* Sum is greater than 100% due to multiple responses.

** 48% did not answer this question or stated that no improvements were necessary.

A further point to note is that only twelve percent of the statements regarding needed improvements referred to the participants or trainees. This becomes clear when one looks at the responses regarding what was the best thing about the session (see Table 7-5). By far, trainees' conduct was the most positive part of the sessions. The extent to which this is true is quite overwhelming and positive. As discussed elsewhere, the enthusiasm of the trainees was pronounced and permeated all discussion of training. This becomes particularly interesting considering the fact that there had been such initial concern regarding trainee motivation and their expected wide range of educational background. There was much concern over training

Table 7-5

Best Thing About Training Sessions
As Described By Trainers

Categories of Comments	Percent*
Trainees: class participation	37%
Trainees: sharing and interaction with each other	25
Trainees: attitude, eagerness to learn, motivation	20
Specific format	20
Specific topic	8
Relevant, useful to trainees	6
Resources	6
Experiential, hands on, not abstract	3
Miscellaneous	3
Vague	3
	(N=436)

* Sum is greater than 100% because of multiple responses.

preparation for such a population. Obviously, the positive and unanticipated behaviors of the trainees overshadows all else in the trainer descriptions of what they liked best concerning the training. Also, as indicated in Table 7-5, twenty percent of the trainers did describe a particular format which they especially liked. There was no consensus because they tended to mention very specific, almost idoiosyncratic, format items (e.g. specific film). Thus, from an information viewpoint, little was learned about the variation in sessions themselves because the trainers were so pleased about the trainees' attitudes and behavior. Of course, with such positive descriptions from the trainers, one cannot help but believe that, whatever the format and topics of the sessions, the trainees were learning.

Chapter 8
Outcomes - The Trainees' Perceptions, Attitudes and Knowledge

The following chapter describes the three levels of trainee evaluation outcomes assessed in this project: (1) their perceptions of the training, (2) their child care attitudes and knowledge, and (3) their behavior.

Level I: Trainee Perceptions of Training

Session Ratings. One of the most ambitious undertakings of the evaluation procedure was its assessment of the trainees' reactions to every training session. If this were assessed thoroughly, a worthwhile prediction of trainee reactions to future training of similar types could be made. The instrument developed for this purpose was the Caregiver Training Session Reaction Form (CT) (see appendix A). Trainees completed one form at the end of every training session, indicating their reaction to six statements ranging from a score of 1 = strongly disagree to 5 = strongly agree. These statements are shown in Table 8-1 on page 73.

Responses to the items were overwhelmingly positive and included very little variation between sessions. In fact, of the sixty mean scores, the lowest for any item on any single session was 4.01 and the highest mean score on any item for a single session was 4.48.[1] Because there was so little variation in response, it was not worthwhile to analyze trainee reactions by type of format or by the topic covered. That is, they made very little distinction between formats or topics.

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[1] Table 8-A in Appendix C presents the means and standard deviations for each session (1-10) for the six basic items that were presented on the CT form.

Table 8-1

Session Three Training Reaction
Means By Type of Provider*

Item	Provider**		t value	2-Tail Probability
	Home (N=376)	Center (N=526)		
I enjoyed this training session.	4.49	4.40	2.11	.035
The trainer understands the kinds of problems I face in my center or family day care home.	4.44	4.38	1.34	N.S.
There was about the right amount of time for questions and discussion.	4.13	4.24	-1.89	N.S.
I learned new information about child care from this training session.	4.45	4.29	3.09	.002
I will try some ideas from today's session.	4.50	4.43	1.52	N.S.
Overall, this session was very helpful and useful to me.	4.49	4.36	2.80	.005

*The response scale was 1 (strongly disagree), 2 (disagree), 3 (neither agree nor disagree), 4 (agree), and 5 (strongly agree).

**Of the 1224 trainees who turned in Caregiver Training Session Reaction Forms during session three, seventy-five percent of them could be identified by place of work (home or center).

It was expected that the least positive training session reactions would occur for the first session. First, there were many forms to be completed at that session, including two evaluation forms. Second, trainers had only a short period of time during the first session to get to know their trainees and to present them with an orientation to the training process. In looking across sessions, it does appear that the first session had slightly lower mean reaction scores than did later sessions. The six means for session one ranged from 4.05 to 4.33 while those for session five, for example, ranged from 4.26 to 4.48. It is interesting to note, however, that the mean for item one, "I enjoyed this training session", was high, even on session one. Despite all the difficulties that were inevitable for a first session, the trainees overwhelmingly reported that they enjoyed it. It appears that the sessions were, indeed, always perceived as enjoyable since item one had the highest mean of the six items over all the sessions. (The range of these means for item one was 4.33 to 4.48.)

Since center and home providers came to training with somewhat different needs and backgrounds, it seemed essential to assess the possibility that center and home providers reacted differently to the training experience. Session three was chosen to investigate this question for some of the following reasons. First, the initial two sessions were often involved with the mechanics of start-up, with orientation, and with the process of getting to know one another. By the third session, the full educational program of the ETU was usually in full swing. Second, choosing a later session for analysis would have resulted in the loss of trainees in ETU's that met for only a few sessions. Therefore, session three was deemed the best choice for this purpose. Table 8-1 presents the mean responses for home and center trainees.

Although all of the ratings were very positive, it is obvious that home providers were generally more positive in their session reactions than center providers. Only on item three, the amount of discussion time, was this trend reversed. For three of the six items, the differences between the reactions of home and center providers were significant. Home providers expressed higher levels of enjoyment, learning of new information, and perceived usefulness of the session than did center providers. Further, these responses have an internal consistency. That is, since some home providers learned more new information (item four) than center providers, it would follow that they would find the session significantly more helpful (item six) than the center providers. Then, it is not surprising to find that home providers enjoyed the session more (item one) than center providers.

Such differences may be related to the differential rate of previous training experience between these two groups which was discussed in Chapter 4. Fewer home providers had college courses related to child care, or conferences and workshops, than had center providers. In fact, the center providers brought a different background and employment experience to the training situation than did the home providers. This, in turn, differentially affected what they took away from the training experience. In addition, it is important to remember that home providers are relatively isolated from other adults during their working hours, whereas center providers work and interact with other adults all day. This fact alone may account for the greater ratings of enjoyment by home than center providers. Not only were the home providers able to meet and socialize with new acquaintances, but these people were their colleagues. Home providers were very gratified by this training, although clearly the center providers also found it very worthwhile.

The extent of the positive reaction from all the providers is especially outstanding when one considers the fact that the questionnaires were anonymous and confidential. Trainees were allowed to use their maiden names and all forms were sealed before they were turned in. There was no reason for trainees to be other than open and honest about any misgivings they may have had about a training session. Some trainers believed that where there were a number of sessions for an ETU, the trainees gave less thought to their evaluation responses at the later sessions. The distribution of responses, however, did not indicate any such bias. Thus, it must be concluded that trainees found the training sessions most enjoyable, useful and informative about child care.

Overall Training Rating. It was important to obtain an appraisal of the total training experience from the trainees. Therefore, at the last session, the question was asked, "Overall, how would you rate your training experience here this summer?" As indicated in Table 8-2, the average rating was "very good" (mean = 4.06), with three fourths of the trainees feeling the training was very good or excellent. Again, these responses confirmed earlier findings that home trainees were more positive in their evaluations of training than were center trainees.

Table 8-2

Rating of Total Training Experience
By Type of Trainee

Rating	Provider (Percent)		
	Home	Center	Total
Poor	0.0%	0.8%	0.5%
Fair	3.3	5.2	4.5
Good	11.4	23.6	19.4
Very good	46.0	44.3	44.9
Excellent	39.3	26.1	30.7
TOTAL	100.0	100.0	100.0
Mean	4.21 (N=333)	3.90 (N=639)	4.06 (N=972)

Chi Square = 33.68, df = 4, p < .000.

The explanations for this finding are the same as those described for the session three results. In addition, by the end of training, there was time to implement some of what the trainees had learned. During the course of training, it may have been less possible for center than home providers to implement new caregiving ideas and techniques. Center providers would have had to involve the director and other staff who were not part of the training in decisions about the desirability of a new procedure. Yet the home provider, as an independent business person, could try out new ideas on her own.

Bringing feedback to the group about these experiences would maintain a high level of involvement and satisfaction. Anecdotal reports suggest that this sometimes occured. Such a process difference may be reflected in the overall training ratings and should be further explored in future project evaluations.

Pre-Post Ratings Of Competency Topics. The trainees were asked, at the initial training session, to rate the amount of training that they wished to receive in each of the sixteen competency topics. At the completion of their last session, they indicated the amount of training that they had actually received in each topic.

When the initial competency topic ratings are examined (see Table 8-3 below) for information concerning perceived training needs, it is clear that home and center providers agreed about which topics were their top six priorities for training. These were discipline, curriculum content, educational process, play, working with parents, and safety. This is encouraging because such results imply that training home and center providers together was feasible in terms of their basic, self-perceived training needs (see Table 8-4 for mean scores).

In order to assess, from the trainees' viewpoints, where the training received matched their initial needs and where it did not match them, a multivariate analysis of variance was performed. The two independent variables were type of provider (home and center) and time (pre and post). The multivariate analysis indicated that there was a statistically significant difference between scores for home and center providers, that scores differed between the pre test and the post test, and that the pattern of change differed for home and center providers.[1]

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[1] Main effect: Type of Provider, Multivariate $F=8.05$, $p < .001$.
Main effect: Time, Multivariate $F=57.10$, $p < .001$.
Interaction effect: Type of Provider x Time, Multivariate $F=2.41$, $p < .01$.

Table 8-3

Perceived Training Needs for Competency Topics

Competency Topic	Home Providers (Percent)						Center Providers (Percent)					
	Training Needs						Training Needs					
	Very Little	A Little	Some	Much	Very Much	Total (N=487)	Very Little	A Little	Some	Much	Very Much	Total
Human growth & development	6	11	42	18	23	100	2	9	30	32	27	100
Health	11	19	36	17	17	100	10	15	34	23	18	100
Nutrition	7	11	30	27	25	100	8	15	31	24	22	100
*Safety	3	7	24	28	38	100	4	7	22	31	36	100
*Education process	2	8	36	30	24	100	1	4	26	34	35	100
*Play	3	7	31	33	26	100	1	5	24	37	33	100
*Discipline	2	4	18	30	46	100	1	3	11	28	57	100
Physical space	7	14	33	24	22	100	4	11	32	29	24	100
Programming	5	13	33	24	25	100	3	8	26	33	30	100
Staff relations	20	25	29	12	14	100	9	15	30	21	25	100
*Curriculum content	2	5	23	33	37	100	1	3	16	33	47	100
*Working with parents	3	11	27	28	31	100	1	6	25	34	34	100
Confidentiality	22	19	34	11	14	100	16	18	30	17	19	100
Legal issues	6	10	30	21	33	100	3	8	26	30	33	100
Understanding self	7	11	36	24	22	100	7	11	29	26	27	100
Other specific subjects	9	11	37	21	22	100	4	11	32	27	26	100

*Six top priority topics.

Examination of the means in Table 8-4 indicates that there was either a pre-post match or increased ratings at the post session for six of the sixteen topics (see A. and B. on Table 8-3). For two topics, home providers had increased post ratings and center providers had decreased post ratings (see C. in Table 8-4). For the other eight topics, there were decreased ratings at the post session (see D. on Table 8-4). It is not surprising that a pre-post match in ratings was not achieved for more than half of the topics: this training program was limited to twenty hours while each of these topics could be taught, as a class in itself, for twenty hours. Certainly, the six topics shared by home and center providers as top priorities could hardly be taught and discussed completely in this short time. In fact, it is true that they did receive less training than initially desired in four of these six priority topics.

Table 8-4

Pre-Post Ratings of Competency Topics by Type of Provider

Competency Topic by Type of Pre-Post Difference	Home		Center	
	Pre	Post	Pre	Post
A. No Significant Difference				
*Educational process	3.79	3.93	4.00	3.91
Nutrition	3.61	3.72	3.29	3.31
Physical space	3.48	3.72	3.59	3.55
B. Increased Ratings				
Confidentiality	2.83	3.15	3.00	3.14
*Play	3.79	4.25	4.00	4.23
Understanding self	3.51	3.79	3.51	3.74
C. Home Increase, Center Decrease				
Human growth and development	3.44	3.59	3.69	3.40
Staff relations	2.74	2.83	3.32	2.99
D. Decreased Ratings				
*Curriculum content	4.07	3.66	4.24	3.67
*Discipline	4.21	3.88	4.40	3.94
*Safety	3.91	3.62	3.90	3.39
*Working with parents	3.78	3.49	3.91	3.35
Health	3.09	3.04	3.27	2.86
Legal issues	3.67	3.27	3.77	3.16
Programming	3.57	3.47	3.81	3.43
Other specific topics	3.43	3.04	3.54	2.98

* The six top priority topics for both home and center providers on the pre-test.

There was, then, an indication of a lack of match in more than fifty percent of the competency topics. While the topic ratings did not include a measure of satisfaction for each individual topic, we have already seen from the session ratings and the overall training ratings that trainee satisfaction was quite high in this project. The amounts of training received on these topics during the twenty hours of training were certainly sufficient to make them pleased with the training program.

It is not feasible to assume that people will be able to assess objectively their own training needs. The trainees in this project would have the same difficulty. Rather, this data was collected to provide additional Level I, or attitudinal data, from the trainees. More objective assessments will be included in the following section of this chapter.

Summary. In essence, the trainees reported consistently strong, positive perceptions of the individual training sessions and of the overall training experience. The surprising element was that it was significantly more positive for home providers than center providers. Nevertheless, home and center providers agreed on their choice of the six topics out of the sixteen on which they wanted the most training.

Level II: Trainee Child Care Attitudes and Knowledge

One of the major concerns of the evaluation team was that of assessing trainee improvements in child care knowledge. Although the problems associated with measuring this are discussed in Chapter 2, it should be noted here that when the evaluation was designed it was assumed that an existing, validated, assessment instrument would be utilized to measure trainee knowledge. Reviews of textbooks, journal articles, and testing manuals, as well as interviews of twelve to fifteen child development experts, failed to locate an appropriate instrument for this population. An instrument, therefore, was designed specifically for this project (see Appendix A, Caregiver Survey).[1]

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[1] Unfortunately, there was no time to validate this instrument. It did, at least, have the benefit of a series of pretest reviews.

Three sections with different formats were included in order to tap different areas of potential growth as a result of training. The first section contained twelve items that described common situations faced by providers in the topic areas targeted for training by the master contractor. For each item, the trainee was asked to select one behavior (from three possibilities) that would be the best response to a provider job situation. This section assessed knowledge of appropriate behaviors in very specific situations.

In the second section, trainees were asked to show on a five-point scale how much they agreed or disagreed with twelve attitude statements about child care. Although some information about child development was needed to answer these questions correctly, they also each involved an aspect of the child care philosophy endorsed by the master contractor.

The third and last section of the Caregiver Survey contained twelve true or false statements designed to assess child development and caregiving information. All of these statements were factual; the answers to all of the questions but one were verifiable by current child development textbooks. The one question that would not be included in a textbook involved the Michigan state law that all cases of actual or suspected child abuse must be reported by providers on a particular form to the Department of Social Services.

Post Test Scores of Trained Providers. There are a variety of ways in which training results can be assessed. The first step taken was to examine differences in scores between home and center providers on this instrument which was administered at the final session. When post training scores for these two groups are compared, it is evident that as a total group they scored quite high (see Table 8-5 below). Further, home and center trainees scored very similarly on the child care situation (I) and philosophy (II) parts of the instrument. However, home providers scored higher on the information section (III) of the test than did center providers. Although the difference between the scores is quite small, this difference is statistically significant and therefore must be acknowledged.

Table 8-5

Scores on Knowledge Questionnaire
By Type of Provider

Subject Section	% Correct		Highest Score Possible	Mean Score		t value	2-Tail Probability
	Home (N=341)	Center (N=663)		Home	Center		
I. Child Care Situations	83.5	82.4	12	10.02	9.89	1.14	N.S.
II. Child Care Philosophy	81.2	81.4	5	4.06	4.07	-.35	N.S.
III. Child Care Information	77.6	75.2	12	9.31	9.02	2.38	.018

Contrast Group: Response Rate. As described in Chapter 2, the primary analysis of training results was to be a comparison of the Caregiver Survey (CS) scores of an untrained contrast group of home providers from across the state to the scores of home providers trained in the project. Only home providers could be studied in this way since names and addresses of an appropriate group of untrained center providers was, in fact, not available to provide a contrast group. The contrast group was selected, as described in Chapter 2, by sampling from the responses to an MDSS mailing to all certified providers in the state. It was important that the sample be chosen so that possible selection biases between the untrained and the trained group could be minimized. Both groups were interested in training but the untrained group never received training.

The response rate for this mailing was one of the most unusual findings in the entire evaluation. It is common for response rates for mailed surveys to vary between twenty and forty percent (Helmstadter, 1970). As indicated in Table 8-6, seventy-two percent responded to this questionnaire. In fact, this is an underestimate. It was not possible to designate, prior to mailing the surveys, those who had actually received training (and were therefore ineligible for the contrast group). Therefore, they were instructed to return the blank questionnaires. Many of the 77 persons who did not respond were undoubtedly trainees (ineligible for the contrast group) who did not bother to return the blank questionnaire.

Table 8-6

Contrast Group Response Rate

Questionnaire Categories		Number	Percent
Total questionnaires:	Mailed	276	100.0
	Returned	199	72.2
Contrast Group		(149)	(54.0)
Ineligible *		(50)	(18.1)

*Trained respondents who returned blank questionnaires.

The response rate may have been slightly improved by two factors: (1) MDSS had made a previous mail contact with all persons on the list, and (2) each untrained provider who returned a completed survey instrument was promised and mailed a packet of free pamphlets. These pamphlets covered a range of topics of interest to child care providers such as nutrition, first aid, and so forth. Fifty-five percent of them signed their names and addresses so that the materials could be mailed to them. Above and beyond these contributing factors, however, this unusually high response rate undoubtedly reflects the high level of provider interest in training. It appears that home providers in Michigan are especially eager and motivated to cooperate with a provider training project such as this one.

Contrast Group: Comparative Analysis. The purpose of obtaining data from this group of untrained providers was to compare the scores of the trained home providers with those of the untrained home providers in the contrast group. The contrast group method of determining trainee knowledge gains has some advantages over the usual pre-post method (Campbell & Stanley, 1963) for the reasons cited in Chapter 2. In this case, with such a high response rate from the contrast group, as well as the fact that all of these providers had already expressed a desire to receive training, the contrast group method has validity. The possibility of selection bias as an interpretation of any differences in outcomes between the two groups is reduced by these two factors.

Table 8-7 below presents the comparison of CS scores obtained for this method of analysis. While the mean scores for all three sections of the instrument are higher for trained than untrained providers, only the difference for the section III mean scores are significant. It is clear that training had an impact upon home providers.

Table 8-7

Knowledge Questionnaire Mean Scores
for Trained and Untrained (Contrast Group) Home Providers

Subject Section	Percent Correct		Highest Score Possible	Mean Score		t value	2-tail Probability
	Untrained Home	Trained Home		Untrained Home	Trained Home		
I. Child Care Situations	82.5	83.5	12	9.90	10.02	.73	N.S.
II. Child Care Philosophy	80.6	81.2	5	4.03	4.06	.80	N.S.
III. Child Care Information	73.7	77.6	12	8.84	9.31	2.55	.011
				(N=142)	(N=341)		

Why did significant differences show up as a result of training only for the third section of the Caregiver Survey? One possibility is that more training time was addressed to child care knowledge than to the other two aspects of child care competence assessed by this instrument. Another possibility is that the first two sections of the instrument contain "common sense" items with which most providers are familiar without training. Sections I and II may not be sufficiently difficult to tap training improvements in these aspects of child care. During various stages of survey development and use, the CS instrument was administered to a number of different groups. In all cases, a larger percentage of correct responses were obtained on the first two sections of the survey than on section III. It is clear that this was the most difficult section of the instrument for both trained and untrained persons.

It is indeed encouraging that a significant difference in child care information levels was found between trained and untrained providers from across the state after only twenty hours of training. Furthermore, it was a standard instrument, administered across ETU's, regardless of their choice of formats or particular training topics. When one considers that, without mandatory curricula or training objectives, these subcontractors were able to implement varied training programs that resulted in overall home provider knowledge gains on a standard instrument, this outcome is particularly impressive. Home providers showed significant gains in child care information as a result of this training experience.

Comparison of Pre-Post Scores of a Trained Subgroup. The original design did not include administering this knowledge questionnaire prior to and again after training. The reasons for this decision were discussed in Chapter 2. However, to clarify the results of other methods of assessing training impact on knowledge about child care, a selected subgroup of almost one hundred trainees did complete the Caregiver Survey both before and after training. It should be noted that these groups do not represent a cross section of the total group trained in this project. The seven ETU's which participated in this comparison all started training in early September.

As indicated in Table 8-8, for this group of 99 home and center providers, it is clear that scores consistently improved on all three measures from the initial to the final session of training. Thus, the pre-post comparison of scores reveals improvement in more areas of

Table 8-8

Pre-Post Knowledge Questionnaire Scores*

Subject Section	% Correct		Highest Score Possible	Mean Score		t value	2-Tail Probability
	Pre	Post		Pre	Post		
I. Child Care Situations	78.1	82.6	12	9.37	9.91	2.89	.005
II. Child Care Philosophy	77.6	80.6	5	3.88	4.03	4.05	.000
III. Child Care Information	71.3	74.3	12	8.56	8.91	1.97	.052

* N = 99; Home Providers = 35, Center = 54, Type of Provider Unknown = 10.

child care knowledge and attitudes than does the home contrast group - home trained group comparison discussed in the previous section. These two assessments are not equivalent for several reasons. The paramount difference is that the pre-post trained subgroup contained both home and center providers, while the contrast group-trained group comparison contained only home providers.

On the other hand, the pre-post group is a small group that is not representative of the whole trained population. In addition, there is some indication that after taking the pretest some trainees sought out information concerning items on the test which had been difficult for them. Therefore, when it came to the post test, they were better able to answer the questions. This is one of the standard difficulties of a pre-post design.

In essence, the pre-post comparison was used in this project to supplement the other evaluation findings. The results are positive and consistent in many ways with these other findings.

Level III: Pre-Post Home Provider Behavioral Observations

The ideal assessment of training is to measure its impact on the providers' behavior with children. For the most part, this remains ideal because the measuring instruments remain quite experimental and the cost, both in time and money, are enormous. Nevertheless, as a beginning, the actual provider behavior of one small group of nine home trainees[1] was assessed by pre and post home observations.[2] The observational instrument (Stearns and Urberg, 1981) contained items in fifteen different areas of behaviors or scales. (The instrument and definitions of these fifteen scales are presented in Appendix A.) Interobserver agreement for each scale was assessed by calculating the percentage of agreement between the ratings of two observers.[3] These fifteen percentages ranged from .50 to 1.00. The percentage of agreement calculated over all items in all scales was .85. Out of a total of 159 items scored, the two observers agreed on the scoring of 135 items and disagreed on 24 items. This is considered an acceptable level of observer agreement for such an observational measure.

As shown in Table 8-9, there is an improved score after training in thirteen areas. This improvement is statistically significant in five areas: materials/toys, balanced activities, divided areas, small motor playthings, and messy activities. The two scales, materials/toys and small motor playthings, both mean that specific, appropriate materials for children were provided in more adequate quantities after training than before. Providers had purchased and/or made new toys and learning materials for the children during the training period. In addition, as shown by the scale, divided areas, the play room(s) of their home was arranged in a different way after training. They now had toys and materials arranged according to activity, such as a quiet area for books and visual exploration of materials, a large motor area for climbers and wheeled toys, a doll or dress-up area for fantasy play, and so forth.

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[1] The final sample consisted of nine home providers, six from one ETU and three from another.

[2] This set of data was collected by Maribeth Stearns and Dr. Kathryn Urberg, Department of Family and Consumer Resources, Wayne State University, as master's thesis research.

[3] The percentage of agreement was the ratio of the number of agreements to the sum of the number of agreements plus the number of disagreements.

An important area where improvement was observed was in balanced activities, which included an assessment of the degree of balance between adult-directed versus child-directed activities, the balance between quiet and active play, the time spent teaching concepts, watching T.V., playing outside, and taking naps. The fact that caregivers improved on this scale is very encouraging since the

Table 8-9

Mean Pre-Post Home Observation Scores, N=9

Observation Scale Category	Range Possible	Score		t value	Two-tail probability
		Pre	Post		
Environment	3-6	3.89	4.44	1.35	N.S.
Amount and type of equipment	3-6	4.89	5.67	2.13	N.S.
Materials/toys	3-6	4.11	5.78	5.00	.001
Balanced activities	7-14	11.00	12.67	4.47	.002
Self-help skills	2-4	2.78	3.33	1.35	N.S.
Discipline	6-12	8.78	9.56	1.49	N.S.
Interaction skills	8-16	13.11	14.78	1.56	N.S.
Meals	2-4	1.56	2.11	.76	N.S.
Nutrition	2-4	3.33	3.56	1.51	N.S.
Records	4-8	6.22	6.67	.39	N.S.
Areas	1-2	1.22	1.78	2.29	.051
Motor playthings	1-2	1.22	1.67	2.53	.035*
Daily schedule	1-2	2.00	2.00	.00	N.S.
Messy activities	1-2	.78	1.56	2.80	.023
Physical	1-2	2.00	1.78	1.51	N.S.

* It should be noted that reliability for this scale was low.

difference between custodial care and care that promotes child development resides to a great extent in how the child and adult spend their time during the day.

The last scale for which a significant improvement was reported was the amount of messy activities provided for the children each day. At the start, most trainees had been afraid that messy activities such as water play, play dough, and paints would ruin their homes. One session of training was devoted to methods involved in providing messy activities and in keeping these activities under control. In the post observation visits, these providers reported offering more of these activities to their children than they had previous to training. Messy activities involve the kinds of action-reaction cycles of exploration stressed by Piaget and other learning theorists as critical components to cognitive development in the preschool years. These activities are, therefore, highly valued by experts in child development.

Trend analysis indicated that thirteen of the fifteen areas of behavior improved after twenty hours of training with over one third of these being statistically significant improvements. This certainly is one measure of training success for these participants. While evidence was collected from only a small group, these results support a series of other trainee outcome measures that all point to provider gains as a result of training. This level of evaluation (level III) was utilized to determine if there was any indication that positive effects on trainee perceptions, attitudes and knowledge could or would be translated into actual behavior changes. These results do give us such an indication. It appears that these home providers modified their homes and their behavior in ways that should facilitate the growth and development of the children they serve.

Summary

This chapter has reviewed the assessments made of outcomes for the providers who were trained in this project. Whether perceptions, knowledge measures, or behavioral observations were examined as training outcomes, it was clear that there were positive training results. Furthermore, the total picture of outcomes was a consistent one: providers rated the training as an enjoyable and worthwile experience, they exhibited gains in child care knowledge, and a small subsample showed positive modifications in their behavior as providers.

Throughout the data, there is evidence that home and center providers were somewhat different in their response to training. This is logical since they have backgrounds that differ (see chapter 4) and professions that, while similar in many ways, require settings, schedules, staff, and payment patterns that differ. The ultimate conclusion that is reached after integrating these results, however, is that the home and center providers reached by this project, trained in a multitude of ways, and in a variety of different communities accross the state, showed positive reactions to training as well as indications of increased child care knowledge. Although no single assessment of training impact was sufficient, the sum total of all assessment results demonstrates that, in a variety of ways, this program was effective in training child care providers.

Chapter 9
Outcomes - Unanticipated

It is often true that a training project generates significant outcomes that were not anticipated at its inception and it is the role of the evaluator to be sensitive to these. The following outcomes represent some of the most important unanticipated findings in the current project.

1. Many trainees want and, indeed, are seeking further training. One of the most consistent outcomes was the frequency of reports across the state that trainees desired more training after completion of one ETU. Several subcontractors reported that their trainees planned to seek additional training, either through enrollment in college courses or by less formal means, through conferences and workshops. One subcontractor reported more than fifteen calls to inquire about the possibility of additional training. Many inquiries were directed to the trainers, to local 4-C organizations, and to local family day care councils about the availability of future training. In response, at least one local family day care council expressed a commitment to the development of some carry-over of training into their fall meetings. It appeared that many trainees were surprised to discover that there could be a "match" between their background and the training being provided. Some trainees said, "I didn't know that I could go back to school and now I see that I can". There can be little doubt that this new attitude toward training will result in increased attendance at child care conferences, workshops, classes, and other types of training for many of the providers trained in this project. For example, several trainees registered as a group at the Metropolitan Detroit Association for the Education of Young Children (DAEYC) conference held late last summer. Further, some trainees have already enrolled in college classes or in Child Development Associate training classes.

2. The trainees had an increased sense of self worth and professionalism, both with regard to their role in the work world and in their contribution to the development of specific children. Because family day care providers work at home, they often have difficulties in enforcing a distinction between their work and personal life. Some home trainees reported a major change in this area because of this training project. For example, some reported they were now able to respond appropriately to the neighbor who typically says, "Since you have other children at home, would you mind watching mine (free) for a little while?" Some reported that they can now set limits on parents who take advantage of them, as a provider at home, by extending the child's stay far beyond the agreed upon time. One subcontractor reported, "At the beginning of our training project, many of the home providers referred to themselves as babysitters, but by the end of the project everyone was referring to herself or himself as a day care home provider". Another subcontractor reported that the trainees came to realize their obligation to the children whom they serve: they came to recognize and to feel strongly committed to their role as a teacher. Many had previously viewed their role as that of a responsible custodian.

3. Husbands of many trainees developed more respect and interest in the work of the child care provider. The trainees discussed the fact that a worthwhile improvement in their lives was the reaction of their husbands to the training project. Husbands, especially those of home providers, began to see their wives in a different light. The fact that his wife was attending professional training sessions involving college credit demonstrated to the husband the recognized, professional status of his wife's occupation. The knowledge that this training program was funded and supported by federal and state governmental agencies meant that the business and professional aspects of such an occupation must be widely recognized by important persons in our society. Providers reported that their husbands and other family members showed more interest and support relative to their child care occupations. Home providers stressed that the support of their families was extremely important to them, since almost every aspect of

their job required modifications of their family's home environment, the family schedule, and their own availability to family members. The trainees themselves viewed this change with pride since it reflected and reinforced their own improved image of their status as a child care provider.

4. Providers increased their affiliation both with informal and formal child care organizations. Trainees exchanged telephone numbers and discussed keeping in touch. It was reported by one subcontractor that centers in their city seemed to be communicating with each other more after training. Trained providers have joined local provider and child care organizations or plan to form such organizations in locales where they did not exist. Subcontractors, for example, reported that home trainees in several different counties joined the local family day care council. Trainees discussed plans for the formation of family day care associations in several different counties. A dramatic increase in membership in the existing Family Day Care Provider Association in one county was reported: membership increased fifty percent after training. In this way, providers could maintain a support network as well as receive additional inservice training and information.

The possibility that improved self-images and other training gains might fade over time was expressed by some trainees. At a meeting of the local advisory board for one subcontractor's training project, one home provider said,

> We now feel lost. We planned on it [the training]. We had it, and now we have nothing going on like that.

Thus, membership in local provider organizations will ameliorate this to a great extent.

5. Trainee implementation of new learning in their work sometimes provided models for other providers in their center or changed center policy. For example, the day after one center provider attended a

session on first aid, a child fell from a climber in her center and she was able to cope appropriately. This behavior provided a model for other staff members at her center. In some cases, centers decided to fill out applications to be a part of the USDA Child Care Food Program as a result of information brought back to the center by trainees.

Not all attempts at implementing new information and skills were positive, however. Center providers found that new ideas were sometimes opposed by their director or by other staff members who had not attended training. In one case, a trained provider felt that a licensing consultant who visited her center had not required of her center the kind of standards necessary for quality child care. The following outcome addresses this concern.

6. A new advocacy role for quality child care was assumed by many trainees. This new advocacy role involved many potential benefits for the trainees and for the children they served. Field trips to local centers and homes, as a part of training, inevitably led to class discussions of licensing regulations, the ethics involved in reporting violations, and the role of the child care professional as an advocate for the rights, safety, and welfare of young children. One subcontractor stated that Public Act 235, concerning visitation of family day care homes, was influenced by a concerned home trainee from one of her classes. Interest in their role as child care advocates might also have been one of the reasons many trainees joined child care organizations. These groups were seen as key advocates for quality child care in Michigan, and therefore, as important to support for the improved welfare of children and providers.

7. The providers trained in this project were viewed as more competent by other persons in the community. In at least one case, a MDSS Child Care Licensing Consultant requested the names of trained home providers so that referrals of parents could be made by informing them of providers in their community who had been trained through the project. In some communities, the local newspaper featured an article

or series of articles about the training project. For example, in one area, several articles were carried over a two-week period concerning day care that described the training program of the subcontractor in that city.

8. *The utilization of resource people in the community as speakers for training sessions resulted in mutual effects: it led to a reduction in the sense of isolation felt by providers within the community as a whole and also informed the resource people about child care in their area*. Many resource people were not well informed about home providers and some were unaware of the kinds of problems providers face in providing quality child care. Valuable contacts among persons, as well as among agencies, within communities were set up by the use of professional resource persons as trainers. For example, the county Family Day Care Provider Association in one area now receives continuing consultation from staff personnel in a child guidance agency as a result of their contact during training. In other cases, trainers reported that trainees had started to call various resource persons or their agencies for informal consultation from time to time. In one community where cable television was used to present training sessions, non-providers in the community reported watching and becoming more aware of the issues involved in the provision of quality child care.

9. *The possible use of foster grandparents as substitute caregivers in day care homes was discussed as a result of one training model*. One trainer visited the house of each home provider with a foster grandparent who interacted with the children while the trainer and home provider talked (see Chapter 6). An important spin-off of this method of training was that home providers began to discuss the possibility of using substitutes in their homes for child care. Many had assumed a satisfactory substitute arrangement was not possible until they saw how well the foster grandparent was able to function in this role.

10. Many trainers compiled, developed, and distributed written childcare materials. Several subcontractors developed "resource notebooks" of mimeographed and free materials on first aid, nutrition, classroom learning activities, and so forth, that were distributed to trainees. Often trainees reported that they intended to keep these up-to-date by making calls and inquiries later, on their own, for free materials. Many had been unaware of the useful and inexpensive nature of such materials. One subcontractor developed four printed manuals as a result of the project. These manuals dealt with training, meals, teaching children, and the business aspects of day care homes. These manuals were distributed to the providers and were printed in quantity as a resource for other home providers who request such information.

11. The extent to which center providers in this project were trained with home providers was related to their knowledge scores at the end of training. Throughout the project, the subcontractors, trainers, and the master contractor were interested in the question of whether it was more productive to train home and center providers together or separately. In some locations, mixed training occurred as a matter of efficient training delivery since not enough providers of one type could be enrolled to fill an ETU within a specific geographic area. Scheduling considerations were also sometimes involved. In other cases, decisions were made to present mixed or unmixed training based upon the subcontractor's view of what would produce the most effective training.

Although the question of the "training mix" had not originally been posed in the evaluation design, data were collected that could be used to suggest an answer to this question. Training mix was defined in the following way:

1. No mix: all providers in the ETU are of the same type.
2. Low mix: less than 25% of the trainees were of one type (home or center).
3. High mix: more than 25% but less than 75% of the trainees were of one type.

The mean knowledge questionnaire score for home and center providers for the three levels of training mix are illustrated in Figure 4 below. Except for the home providers' scores on section III, it appears that the greater the integration of home and center providers during training, the higher the scores obtained by these providers.

An analysis of variance was performed on the scores for each section of the knowledge questionnaire, separately, to examine statistically the effect of training mix and type of provider. The results for the first two sections of the questionnaire, section I and II, are consistent. They indicate that, overall, both types of providers scored higher to the extent that they were trained together.[1]

The results for the most difficult section of the instrument, Section III, were especially interesting (see Figure 4). Overall, there was a difference in the scores of home and center providers,[2] as discussed in Chapter 8. Again, as for sections I and II, overall, the training mix was important.[3] The most crucial finding for section III was that home and center providers did not respond to training mix in the same manner.[4] Home providers' scores were higher when they were trained in a homogeneous group, while center providers' scores increased in proportion to the percentage of home providers with whom they were trained.

Furthermore, correlational analyses substantiate these findings, as indicated in Table 9-1. There was a relationship between training mix and scores for center providers but not for home providers. Although the sizes of the correlations are quite small, they are statistically significant concerning this important aspect of training delivery.

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[1] Section I, main effect: Training Mix, $F(2,963)=13.38$, $p<.000$.
Section II, main effect: Training Mix, $F(2,963)=9.39$, $p<.000$.

[2] Section III, main effect: Type of Provider, $F(1,963)=5.14$, $p<.024$.

[3] Section III, main effect: Training Mix, $F(2,963)=4.89$, $p<.01$.

[4] Section III, interaction: Type of Provider and Training Mix, $F(2,963)=4.36$, $p<.01$.

Figure 4

Mean Scores on Knowledge Questionnaire by Training Mix and Type of Provider

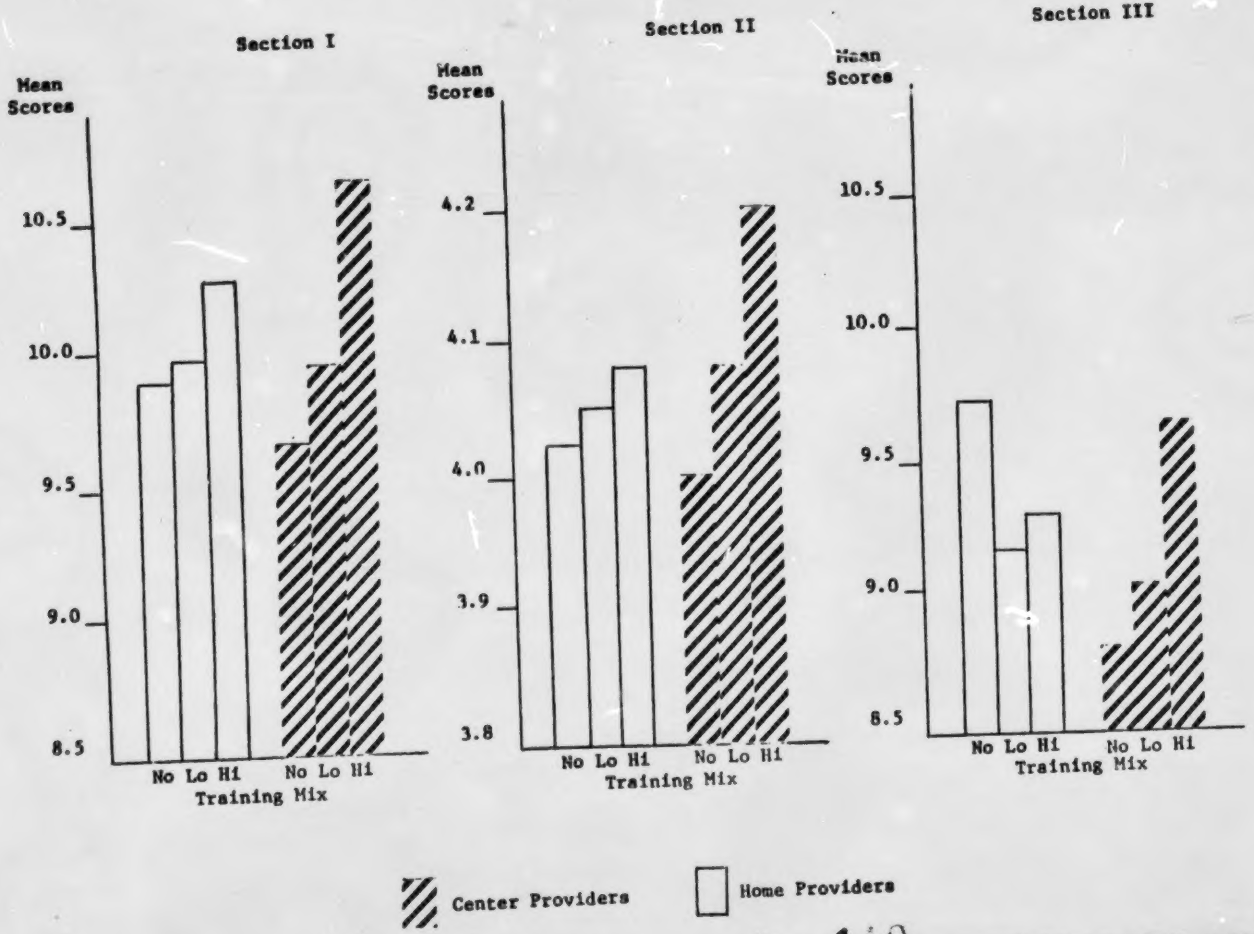

Table 9-1

Correlations Between Mix of Training and Knowledge Questionnaire Scores By Type of Provider

Subject Section	Providers			
	Home		Center	
	Correlation (r)	Probability	Correlation (r)	Probability
I. Child Care Situations	.08	N.S.	.19	.000
II. Child Care Philosophy	.04	N.S.	.16	.000
III. Child Care Information	-.05	N.S.	.15	.000

Many views were presented during the project concerning the relative advantages and disadvantages of mixed training, yet no one suggested that it might benefit one type of provider more than the other type. Perhaps even more surprising than the fact that this was found to be the case for section III scores, is the direction of the finding. Many might predict that center providers in this project, with their higher educational levels and greater exposure to workshops and conferences, would be able to provide important stimulation for the home providers. Yet it was the center providers who benefited more from training contact with the home providers.

Before considering interpretations of these results, it is important to note the fact that these trainees were not randomly assigned to a type of training mix. Any effect of training mix may be related to whatever factors underlay the subcontractors' decisions about the composition of ETU's by type of provider. Undoubtedly, there were a variety of such factors.

With this information in mind, some possible explanations of these findings will be considered. One possible explanation involves the question of whether or not the content of Section III was equally relevant to both types of providers? An analysis of the CS instrument reveals that the items are not biased toward one type of provider or the other. Thus, the nature of the instrument does not offer an explanation.

Another possible explanation lies in a consideration of possible motivational differences between home and center providers. If home providers were more committed to and enthusiastic about training than center providers, home providers might have injected an important element of positive affect into mixed groups. This added element might have resulted in more learning for the center providers.

As discussed in Chapter 8, home providers did report enjoying the session more, learning more, and finding the session more useful than center providers. On the final rating of the total training experience, it was also found that home providers viewed the experience more positively than did center providers. Although both groups were very positive about the training experience, it does appear that there was some difference in the intensity of their reactions. This affective difference between types of providers may have resulted in the differential impact of training mix on home and center providers.

Summary

In summary, it is clear that the impact of training operated at several levels to affect not only the individuals trained but also their families, colleagues, and other individuals in the communities where they provide child care. Most of these outcomes imply an improved sense of self-esteem for the provider as well as improved perceptions of their role by others. In addition, it appears that training generated connections that will result in less isolation of providers from others and may result in continued training and education. Many appear committed to participation in local provider and child care organizations. These outcomes, especially those that reflect a change in the provider's view of his or her job, are as likely to influence the care of the children they serve as are the anticipated outcomes of improved provider knowledge and attitudes discussed in the previous section. One of the principles delineated in the November, 1975, report of the Training Task Force (see Chapter 1) was that, "There must be tangible as well as intangible rewards for workers who invest their time, effort, and money in training". While tangible rewards such as college credit and Certificates of Completion were available, it is also clear that intangible rewards accrued to the trainees in this project. Further documentation of these outcomes and their impact should be attempted in future provider training projects. In addition, the possible benefits of training home and center providers together should be explored further.

Chapter 10
Summary and Recommendations

This chapter presents a summary of evaluation findings and the resulting recommendations. The prime fact is that the Michigan Day Care Provider Training Project, Year One met the program goals:

- 1662 certified child care providers from 57 counties throughout the state of Michigan were enrolled in the Michigan Day Care Provider Training Project, Year One. 1362, or eighty-two percent completed training including both home (37%)and center (63%) providers.
- The master contractor successfully implemented training through a subcontractor system that maintained the responsibility for training at the local level where it could be flexible and adapted to local needs.
- Trainees were trained in ETU's with the following characteristics: The mean number of trainees per ETU was 14.5; all trainees who completed 20 hours of training received a Certificate of Completion; at least a portion of most training was conducted on site in a day care center or family day care home; and 594 trainees were offered academic credit, while 494 were offered continuing education credits.
- Training topics were chosen at the local level from those targeted by the master contractor--evidence indicates that trainees increased their child care knowledge.
- Local community linkages were developed between providers and community resource agencies. These were further enhanced by the networks that providers developed among themselves and the local child care organizations that they joined.

Summary

Project Organization. The master contractor, CUS/WSU, implemented training through a subcontractor system that maintained the responsibility for training at the local level where it could be adapted to local needs. The fifteen subcontractors covered a broad area across the entire state. Eleven were institutions of higher learning.

It became the role of the master contractor to develop and pass along the training philosophy, basic structure, and curriculum outline. The framework was set within which the subcontractors could operate. This included setting the requirement for twenty hours of training with 10 to 30 certified providers per class who would be trained in those competency topics articulated by the master contractor. Within these constraints, the subcontractor implemented the program according to their assessment of local needs, with the facilitation of the master contractor.

Two major functions were fulfilled by the master contractor staff during this training period. First, they gave what is best defined as psychological support to the subcontractors and their trainers. Second, they attempted to facilitate and aid in ameliorating a large number of technical problems including such diverse activities as defining an "in-kind" match for contract purposes and determining specific trainee eligibility. Future training should be able to minimize these functions while increasing the master contractor's role in curriculum development and in the facilitation of information exchange among subcontractors.

The Project Advisory Committee maintained an unusually active and constructive affiliation with the project from its inception. They had an important role in the development, implementation, and evaluation of the project.

Each subcontractor was required to have a local advisory committee. The work and success of these local committees varied. Often they reflected the same leadership and involvement as the Project Advisory Committee and acted as a strong link to local resources.

Process - The Population Trained. Despite the short time available to the subcontractors for recruitment and planning, all project goals related to recruitment were satisfied. 1662 child care providers, representing fifty-seven counties in the state, were enrolled in this training project. Eighty-two percent completed training. Many of those who did not complete, nevertheless, attended a number of sessions. Thus, over 1600 providers received some training during the summer of 1980. Further, this included a sizable proportion of home providers who had been anticipated as difficult to recruit. The recruitment process was, by necessity, highly concentrated for most subcontractors because of the short planning period. It was made slightly easier by the fact that, in most areas, child care providers were obviously eager for training.

The trainees included representation from numerous ethnic groups; e.g., twenty percent were black and 3.5 percent were Hispanic. There was a greater representation of minorities in the provider group than in the general Michigan population. The trainees came from all size communities, spanning rural to large cities. Their education level was higher than had been anticipated; fifty-eight percent of center providers and forty percent of home providers had at least some college credit. With regard to their enrollment in this training project, most gave reasons for enrollment that expressed a sense of commitment to their work as child care providers.

Process - The Trainers. The trainers in the project were recruited, hired, and supervised by the subcontractors. Most of them had a college degree in a field related to the education of young children. Two thirds had experience in teaching adults and most had experience themselves as a day care staff member. Furthermore, a large percentage were members and/or officers in professional organizations that promote child development and education. The trainers seemed especially well suited to the complex tasks of training implementation for day care providers.

Process - The Shape of Training. It was the basic philosophy of the master contractor that local groups could best determine local needs as contrasted with one modality imposed by a single agency. Therefore, CUS/WSU set few constraints on the training modes; these few included a minimum of twenty training hours and that curriculum should be selected from the total competency topics. Indeed, every possible format, length and type of training session was utilized. No single model worked best.

A series of relatively short (2-hour) lecture sessions in the evening was the most popular format. The master contractor had encouraged the use of local resource persons in the training for a variety of reasons; they were used in a majority of ETU's.

As expected, ETU's included a selection of competency topics rather than all of them. These competency topics, as enumerated by the master contractor, covered those items which trainers agreed should be taught. Other data indicate, however, that there is a need to include information on some other topics (e.g. professionalism).

The master contractor achieved its aim of on-site training. Most ETU's included this but only seventeen percent involved observations of children. Although it is difficult to work out the logistics of incorporating children either for observation, or simply child care, a few strategies were successfully attempted. As expected in a first year program, a few of the choices of format, content and structure turned out to have unexpected disadvantages; most, however, worked well. Future training should take advantage of these experiences through an exchange of information and planning with the master contractor.

Outcomes - Trainers. An important element in the training situation is the attitude and motivation of the trainers. Three measures of the perception of trainers were examined:

1. their perceptions of strengths and barriers to training, (measured both before training commenced and again after it was completed),
2. their ratings of the success of each training session, and
3. their evaluation of the strong and weak aspects of each session.

The positive nature of trainers' reactions can perhaps best be explained by noting the fact that their ratings of barriers to training after the last session was lower than their ratings before the first session. They actually experienced fewer barriers during training than they had anticipated.

Furthermore, individual sessions were rated as successful. In addition, for almost half of all the training sessions, the trainers gave no suggestions as to what could have improved the session. Where there were suggestions, the most frequent one was the desire for more training time. They saw the trainees' class participation, interaction, and attitudes as the most positive aspects of the training session.

From the trainers' viewpoints, therefore, these child care providers were a satisfying group to teach and individual training sessions were successful.

Outcomes - The Trainees. One of the most important aspects of the evaluation was to assess provider reactions and gains as a result of training. Three levels of outcome were assessed for the trainees.

Level I: Trainee perceptions of training: Both with regard to individual sessions and the overall training experience, these providers were very satisfied. With regard to the individual sessions, home providers showed higher ratings than center providers for half of the items on this measure. In addition, home providers reacted to their overall training experience with more intensely positive ratings than center providers. While both types of providers perceived the experience in very positive terms, it did appear that home providers found it especially gratifying. Despite the fact that most indicators showed that home and center providers were different from each other, with regard to the fifteen competency topics, they agreed on the top six priorities for training. They were discipline, curriculum content, safety, play, educational process, and working with parents.

Level II: Trainee child care knowledge: A knowledge instrument was designed specifically for this project. It contained three sections, Section I: Child care situations; Section II: Child care philosophy; and Section III: Child care information, and was administered to all trainees at the last training session.

This instrument was used, in three different sets of analyses, to assess the impact of training on the level of knowledge. First, scores of all trained providers were examined. In general, providers performed well on this assessment. Section III, however, was clearly the most difficult of the three. For this section only, home providers scored higher than center providers.

Second, a comparison was made between the scores of trained home providers and a contrast group of untrained home providers who had indicated a desire for training but never enrolled. This analysis revealed a significant difference between trained and untrained providers on Section III. Despite the variety of training formats and topics across the state, scores on a common instrument demonstrated a positive effect of training: the scores of trained home providers were higher than those of untrained (contrast group) home providers.

Third, a subgroup of 99 home and center providers completed the knowledge questionnaire prior to and again after training. This pre-post comparison confirms the earlier finding of positive training impact. Scores on all three sections of the instrument improved significantly after training.

Level III: Pre-Post Home Providers Behavioral Observations: A small group of nine home providers were observed in their own homes before and after training to assess possible behavioral outcomes of training. One third of the behavioral scales observed showed significant improvement after training. It appeared that these providers modified their homes and their behaviors after training in ways that should facilitate the growth and development of the children they serve.

From all three levels of evaluation, it is clear that there were positive training results.

Outcomes - Unanticipated. There were some outcomes which had not been programmed into the original design or goals. One very encouraging result was the desire on the part of a number of trainees to seek further training. It is clear that the impact of training further operated at several levels to affect not only the individuals trained but also their families and colleagues. Many of these outcomes imply an improved sense of self esteem and professionalism for the provider as well as improved perceptions by others of the job of a child care provider.

With regard to program structure, there appears to be an additional element of success in combining the training of home and center providers. Particularly for center providers, data indicated that they learned more when they were trained with home providers.

These outcomes, especially those which reflect a change in the provider's view of his or her job, may be continued and supported by the fact that the training generated connections among trainees and an increased participation in local provider and child care organizations. These outcomes are as likely to influence the care of children as are the anticipated outcomes of improved provider knowledge.

Recommendations

1. Three types of orientation meetings need to occur before training commences:

First, there should be meetings with relevant resource groups and agencies such as regional and local MDSS workers, local child care coordinating councils, and so forth. These people should have a full explanation of the project in order to enlist their help in making it a success.

Second, the master contractor should have a series of meetings with subcontractors to give them a full explanation of their respective responsibilities, appropriate forms, definitions, timetable, evaluation design and all other pertinent information. These meetings should involve the full detail of these various items. Subcontractors must be provided with written, operational definitions of important contractual, programmatic and fiscal terms, such as what qualifies for "in-kind" match and what constitutes completed training or, conversely, a "drop-out".

Third, trainers need statewide orientation sessions which include procedural information as well as curriculum information. These sessions should acquaint them with the variety of possible training problems and solutions that have been experienced across the state.

2. The disparate educational background of the providers trained verifies the importance of the CUS/WSU model that encourages the local subcontractor to adjust their training curriculum and programming to match the needs of their particular trainees. Any "packaged" curriculum for provider training in heterogeneous groups should be seen as a guide rather than a mandate.

3. Although training during Year One emphasized the psychological support and technical support of the master contractor, these functions should be reduced in future years. Instead, the master contractor should spend more of their program time in curriculum development and distribution. They should see their role as a facilitator of information and experience between subcontractors.

4. When a centralized master contractor is responsible for the coordination of subcontractors who are widely spread geographically and variable in their program designs, a precise and standard system of documentation is essential. The master contractor should monitor the training program in each ETU on common forms that request the names and telephone numbers of trainees (including drop-outs), program formats, schedules, and the total attendance per session.

5. Prior recommendations emphasize the need for the master contractor to develop and distribute curriculum as well as to insist on uniform record keeping. It is exactly these two activities which tend to

solidify and centralize any structure. Thus, it is strongly recommended that these activities be carried on in an atmosphere which maintains as much flexibility and local autonomy as characterized the Year One project.

6. The program should continue to use trainers with education in early childhood, experience in center or home care, and ties to professional child care organizations. When a trainer has experience with only one type of care (home or center) some orientation should be given to acquaint her/him with the other type of care.

7. Many trainers during year one committed an inordinate amount of time and effort to this project. Some of the specific recommendations speak to more work for the trainers. Yet, training should be designed with sufficient budget allocations to fully reimburse trainers to do their work within the specified time.

8. One of the important outcomes of this training program was increased self esteem and professionalism on the part of providers. This attitude change may contribute as much to quality child care as the knowledge gains. It would, therefore, seem advantageous to purposively incorporate this into the curriculum. Those items which fall under the rubric of increased professionalism: (1) awareness and understanding of professional and resource organizations, (2) mechanisms for finding substitute caretakers both for emergency times and during training, (3) mechanisms for center trainees to suggest changes to other staff members or the director & (4) awareness of their child care advocacy role in the commmunity.

9. While the competency topics listed by the master contractor appeared to include most of the training needs of the providers, three areas need to be expanded or dealt with in a specific sense. First, the topic, staff relations, which does not apply well to home providers, should be revised to interpersonal skills with adults. This

topic should include consideration of coping skills and effective solutions to the problems of late parents, collecting payments, neighbors or friends who expect free child care, as well as relationships with other staff members in centers.

Second, some specific, age-related information should be provided for trainees who care for either infants or school-age children. Up-to-date guidelines for infant nutrition and feeding should be included for trainees who care for infants.

Third, some method of including management information for home providers, such as tax issues, small business resources, and liabilities, should be devised.

10. On-site training, especially with children present, should be encouraged by suggesting ways in which complicated logistics for this can be simplified, such as the use of non-trainees as temporary caregivers. On the other hand, since the classroom setting may act to encourage trainees to obtain more education, a combination of sites is probably the optimal design.

11. It is recommended that home and center providers be trained together since data indicated that, in general, providers learned more when they were trained together. At the same time, further study should be made of this aspect of training since there was some inconsistency with regard to its effect on home providers.

12. This project elicited strong provider interest in further training. Various types of continuing education through established institutions should be investigated. At the same time, in locations where other training sources are not available, some consideration should be given to additional training through this program.

13. All parties involved in this training project recognize that twenty hours constitutes the very minimum of training. Thus, it was believed that one function of this training was to stimulate providers to seek

and obtain further training. Indeed, this was accomplished, including actual credit courses for a large number of trainees. In the second year, the project can effectively address this matter in the design of curriculum references, choice of resource people and supplementary information, as well as training structure. All of these can be designed with the goal of stimulating trainees to obtain additional training and education relevant to their work as providers.

14. Future evaluations should take account of the following recommendations:

a. Evaluation design, function, and procedures should be explained to the subcontractors and trainers at the introductory orientation session.

b. Persons who drop out of training should be interviewed to determine the reasons for failing to complete training.

c. Follow-up assessments of a sample of trained providers should be collected six months or a year after completion.

d. More information on the behavioral outcomes of training should be collected to verify the Level III findings in the current project.

e. More attention should be directed toward distinctions between various curricula and program formats.

f. As indicated earlier, further study should be made of the effects of training home and center providers together.

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APPENDIX A

EVALUATION INSTRUMENTS

1. Caregiver Information Survey
2. Caregiver Training Session Reaction Form
3. Caregiver Survey
4. Trainer Perception Survey (before)
5. Trainer Perception Survey (after)
6. Trainer Training Session Description Form
7. Contrast Group - Mailed
8. Instructions for Observation of Home Providers

Center for Urban Studies - Wayne State University A-2
DAY CARE PROVIDER TRAINING PROJECT

Mother's Maiden Name: ____________________

Date: ____________________

Caregiver Information Survey

People come to the training workshops for different reasons and they expect to learn about different things. We need to know why you are coming and what you hope to learn. We need your answers to all the questions -- and it only takes about 20 minutes.

1. Why are you coming to these training sessions?

____
____
____
____
____
____
____

2. How much training would you like in each of the areas listed below? Please circle one number for each subject area to show how much training you would like.

	Very Little	A Little	Some	Much	Very Much
1. What is normal growth and development and what is not normal.	1	2	3	4	5
2. Health - shots, health forms and signs of good health and sickness.	1	2	3	4	5
3. Nutrition, meal service and meal planning.	1	2	3	4	5
4. Safety needs of children and first aid information.	1	2	3	4	5

2. (continued)	Very Little	A Little	Some	Much	Very Much
5. How children learn at different stages of development.	1	2	3	4	5
6. Play - how it adds to the child's development in all areas.	1	2	3	4	5
7. Discipline - helping children learn self-control.	1	2	3	4	5
8. Setting up a play room and choosing toys and equipment.	1	2	3	4	5
9. Planning and scheduling a balanced day.	1	2	3	4	5
10. Getting along with co-workers who have different backgrounds and attitudes.	1	2	3	4	5
11. What children can learn and how to teach them.	1	2	3	4	5
12. Working with parents and giving them support.	1	2	3	4	5
13. When to keep information about other staff persons, children, and families private.	1	2	3	4	5
14. What the law says about the rights and duties of child care staff persons.	1	2	3	4	5
15. Understanding your own feelings as a caregiver.	1	2	3	4	5
16. Other subjects that apply to child care for certain groups, such as single parent families.	1	2	3	4	5

17. Other subject areas? Describe: ______________________________

____

____

3. We have listed some reasons why a person might decide to come to these training sessions. Please read all the statements first and then put a check mark beside your two most important reasons. Pick only your two most important reasons for coming.

___ The director of my center asked me or told me to come.
___ I want to meet and talk with other child care providers.
___ I want to learn more about children and their development.
___ The workshops will help me to do a better job as a caregiver.
___ I am curious about what kind of training will be given.
___ I want to obtain college credit or other training credit.
___ I expect to be paid more after this training.
___ I expect that I may be able to get a better job in the future due to this training.
___ Other caregivers that I know encouraged me to come.
___ I have a specific problem in my center that I expect the training to help me with. What is that problem? ____________________
____

4. As a caregiver, list the things that you enjoy or like the most.

____
____
____
____
____

5. As a caregiver, list the things that bother you the most (such as children fighting, late parents, reading stories, etc.)

____
____
____
____

6. Where do you work? ( ) 1. Family Day Care Home ( ) 2. Child Care Center

7. What age groups do you work with right now in your current job? (Check all that apply.)

( ) under 1 year old

( ) 1 to 2½ years old

( ) 2½ to 5 years old

( ) over 5 years old

8. How many hours do you work each week? ____________________

9. In what kind of area is your family day care home or center? (Please check one.)

( ) 1. Rural or small town

( ) 2. Small city

( ) 3. Medium-sized city

( ) 4. Suburb

( ) 5. Large city

10. How long have you worked in child care, including your present job?

_____ years _____ months

11. What different kinds of experiences have you had in child care? Check all that apply and indicate how long each experience lasted, including your current job.

What kind of experience	How many years or months did it last?	
( ) 1. Day Care Center Staff (teacher, caregiver)	______ years	_____ months
( ) 2. Day Care Center Aide	______ years	_____ months
( ) 3. Day Care Center Director	______ years	_____ months
( ) 4. Day Care Home Provider	______ years	_____ months
( ) 5. Day Care Home Aide	______ years	_____ months
( ) 6. Other ______________________	______ years	_____ months

12. Please check below any kinds of child care training you have had. (Check all that apply.)

( ) 1. High school courses (early childhood education, child development, child care)

( ) 2. College courses for college credit (early childhood education, child development, child care)

( ) 3. Conferences or Workshops

( ) 4. Child Development Associate (CDA) certification

( ) 5. Other - please specify: ____

13. What is your sex? ( ) 1. Male ( ) 2. Female

14. What age group are you in? (Please check one)

( ) under 21 years old
( ) 21 to 30 years old
( ) 31 to 40 years old
( ) 41 to 50 years old
( ) over 50 years old

15. What education do you have? (Check the highest one that applies to you)

( ) 1. Elementary school (highest grade completed: _____)
( ) 2. Some high school (highest grade completed: _____)
( ) 3. High school diploma or G.E.D.
( ) 4. Some college (number of years: _____)
( ) 5. Associate of Arts (2 year college degree)
( ) 6. Bachelor (4 year college degree - B.A. or B.S.)
( ) 7. Some masters level credits (number of credits: _____)
( ) 8. Masters (M.A., M.S., etc.)

16. Please check your ethnic background. (Please check one)

( ) 1. Black/Afro-American
( ) 2. White
( ) 3. Hispanic
( ) 4. Native American Indian
( ) 5. Other - please specify: ____________________

Center for Urban Studies
Wayne State University
DAY CARE PROVIDER TRAINING PROJECT

A-7

Mother's Maiden Name: ____________________
Date: ____________________

Caregiver Training Session Reaction Form

We need to know how you feel about today's training session. Please circle one number to describe how strongly you agree or disagree with each sentence and answer the two questions at the bottom of the sheet.

Please do not write in this space		Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
(16)	1. I enjoyed this training session.	1	2	3	4	5
(17)	2. The trainer understands the kinds of problems I face in my center or family day care home.	1	2	3	4	5
(18)	3. There was about the right amount of time for questions and discussion.	1	2	3	4	5
(19)	4. I learned new information about child care from this training session.	1	2	3	4	5
(20)	5. I will try some ideas from today's session.	1	2	3	4	5
(21)	6. Overall, this session was very helpful and useful to me.	1	2	3	4	5

7. What could have been done to improve today's session? ____________________

(22-25) ____

____

8. What was the best thing about this session? ____________________

(26-29) ____

____

If you have any other comments, please write them below.

CT-6/80

THANK YOU.

Center for Urban Studies - Wayne State University
DAY CARE PROVIDER TRAINING PROJECT

A-8

Mother's Maiden Name: ____________________

Date: ____________________

CAREGIVER SURVEY

PART I. In the following 12 questions, read the three reactions that a provider might have for each situation. Next, place a check in the box on top of the best reaction. Mark only one box for each situation.

1. One day a child who must always be helped to take off his coat and hang it up does it by himself. The provider

☐ A. waits to see if the child will do it again the next day.

☐ B. praises the child for this new accomplishment.

☐ C. tells the child that now he is expected to do this everyday.

2. A four-year-old child spills milk at the table during lunch. The provider

☐ A. helps the child wipe up the spill.

☐ B. wipes up the spill and says nothing.

☐ C. tells the child why this spoils her lunch.

3. Pick out the most healthy snack for a group of preschoolers from those listed below.

☐ A. Hi-C fruit drink
Ritz crackers

☐ B. Apple juice
Cheese slices

☐ C. Canned fruit
Oatmeal cookies

4. A provider must plan a morning activity for a small group of preschool children. The first thing the provider should do is

☐ A. think about each child's needs and interests.

☐ B. look up some learning activities in a book.

☐ C. put out only one or two favorite toys.

5. A group of children is going on a field trip under approved conditions with some providers. The providers

☐ A.	☐ B.	☐ C.
do not discuss the trip since the children will get too excited.	talk about the rules for a field trip only.	discuss where they are going and how they will get there and come back.

6. A child has been bitten by another child. The skin is broken and there is a little bleeding. The provider should immediately

☐ A.	☐ B.	☐ C.
loosely bandage the bite to cover the blood.	wash the area with soap and water for several minutes.	pour alcohol or antiseptic over the area.

7. A preschooler or toddler has just made a painting. The provider looks at it and says

☐ A.	☐ B.	☐ C.
"What is this supposed to be?"	"The tree should be green."	"Tell me about your picture."

8. A father comes to pick up his child who now lives with his ex-wife (who has custody). The father's name is not on the release slip. The provider

☐ A.	☐ B.	☐ C.
keeps the child and calls the mother or others whose names are on the release slip.	lets the child go with the father if the child wants to go with him.	has the father fill out some forms and then lets the child go with him.

9. A provider is caring for four 18-month-old toddlers in a play room with:

1. some adult chairs
2. blocks
3. a child-sized table and chairs
4. record player
5. some dolls
6. pots and pans
7. some small toys
8. a rocking boat
9. a small climber

The next purchase for this room should be

☐ A. drums and drumsticks.

☐ B. stuffed animals.

☐ C. picture books.

10. A parent is 20 minutes late to pick up a child at the end of the day. The provider is angry. She

☐ A. covers up her feelings by talking about other things.

☐ B. says she is angry and repeats the policy about late parents.

☐ C. knows she will not be able to treat this child well tomorrow.

11. One child shows and talks about fear of the dark. The provider

☐ A. carefully explains why there is nothing to be afraid of in the dark.

☐ B. has the child sit in the dark for short periods to get used to it.

☐ C. encourages the child to use puppets to talk about what happens in the dark.

12. A provider meets a parent of one of the children he/she cares for in a restaurant. The parent starts to discuss an incident involving the emotional problems of someone else's child in the provider's care. The provider

☐ A. changes the subject to keep information about the problem private.

☐ B. reports as much as she knows so that this parent will understand.

☐ C. tells the parent just enough about it to satisfy his/her curiosity.

PART II: How do you feel about the following statements? Circle one number for each statement to show how much you agree or disagree with that statement.

	STRONGLY DISAGREE	DISAGREE	UNDECIDED	AGREE	STRONGLY AGREE
1. Children should learn about people from other cultures as well as those from their own culture.	1	2	3	4	5
2. Fathers do not have much of an effect on children.	1	2	3	4	5
3. A provider should do as much as she/he can for a child with a problem before talking to the parents about it.	1	2	3	4	5
4. Preschool children should not be forced to eat anything.	1	2	3	4	5
5. A child who disagrees with an adult should be punished for back talk.	1	2	3	4	5
6. In a large playroom, children should be allowed to move freely from one activity to another.	1	2	3	4	5
7. Dress-up play is worthwhile for boys as well as girls.	1	2	3	4	5
8. A slap or a spanking is often necessary to help children learn to behave.	1	2	3	4	5
9. Painting and dancing are a lot of fun for children but they do not have much to do with learning.	1	2	3	4	5
10. During the preschool years, it is natural for girls to be interested in watching boys stand up to use the toilet.	1	2	3	4	5
11. Too many different providers, or changing providers often, can make an infant or young child feel insecure.	1	2	3	4	5
12. Holding children close when they are upset will teach them to act like babies.	1	2	3	4	5

PART III: Read each of the following 12 statements. Circle the T for true if the statement is true. Circle the F for false if the statement is false. Please circle only one letter for each statement.

TRUE	FALSE	
T	F	1. A provider must have written permission from the parent in order to give a child medicine.
T	F	2. By the age of two years, a child will usually be able to ride a tricycle.
T	F	3. Six-month-old infants who are bottle-fed need to be on formula, not regular cow's milk.
T	F	4. In the state of Michigan, providers are required to report all cases of actual or suspected child abuse on a special form to the Department of Social Services.
T	F	5. Toddlers who are learning to talk understand more words and sentences than they are able to produce in their own speech.
T	F	6. The leading cause of death among children is illness.
T	F	7. Toilet training is usually successful at the age of 12 months.
T	F	8. The following skills are listed in the order that they appear in the developmental sequence of drawing and writing skills: 1. holds crayon pointed down at paper 2. draws circular shapes 3. draws a person with 2 parts 4. prints own first name
T	F	9. It is all right to put a baby to bed with a bottle of milk in his/her mouth.
T	F	10. The number of children who have not been immunized against polio has grown in the last ten to fifteen years.
T	F	11. By two years of age the child can be expected to share toys and to engage in cooperative play.
T	F	12. Physical growth is faster during the preschool years than it was in infancy.

PART IV: How much training did you receive in each of the areas listed below? Please circle one number for each subject area to show how much training you got about that topic.

	Very Little	A Little	Some	Much	Very Much
1. What is normal growth and development and what is not normal.	1	2	3	4	5
2. Health - shots, health forms and signs of good health and sickness.	1	2	3	4	5
3. Nutrition, meal service and meal planning.	1	2	3	4	5
4. Safety needs of children and first aid information.	1	2	3	4	5
5. How children learn at different stages of development.	1	2	3	4	5
6. Play - how it adds to the child's development in all areas.	1	2	3	4	5
7. Discipline - helping children learn self-control.	1	2	3	4	5
8. Setting up a play room and choosing toys and equipment.	1	2	3	4	5
9. Planning and scheduling a balanced day.	1	2	3	4	5
10. Getting along with co-workers who have different backgrounds and attitudes.	1	2	3	4	5
11. What children can learn and how to teach them.	1	2	3	4	5
12. Working with parents and giving them support.	1	2	3	4	5
13. When to keep information about other staff persons, children and families private.	1	2	3	4	5
14. What the law says about the rights and duties of child care staff persons.	1	2	3	4	5
15. Understanding your own feelings as a caregiver.	1	2	3	4	5
16. Other subjects that apply to child care for certain groups, such as single parent families.	1	2	3	4	5

17. Other subject areas? Describe:

PART V: Overall, how would you rate your training experience here this summer? Circle one number to show your reaction.

Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5

PART VI: Please feel free to give any reactions you may have about your training in the spaces listed below.

COMMENTS: ____

SUGGESTIONS: ____

THANK YOU

7/80

Center for Urban Studies
Wayne State University
DAY CARE PROVIDER TRAINING PROJECT

Mother's Maiden Name: ____________________

Date: ____________________

Training Session Location: ____________________

TRAINER PERCEPTION SURVEY

I. Below are listed some strengths that your training sessions may have that you anticipate will aid in their success. Please read each statement and circle the number that best describes how likely it is that this strength will be helpful to your training sessions.

		Not at all Likely				Extremely Likely
		1	2	3	4	5
1.	My educational background.	1	2	3	4	5
2.	My previous day care experience.	1	2	3	4	5
3.	My contacts in the local community.	1	2	3	4	5
4.	The resource materials (i.e., books, films) that I plan to use.	1	2	3	4	5
5.	The support and enthusiasm derived from group discussion and questions.	1	2	3	4	5
6.	My skill in talking with and understanding people.	1	2	3	4	5
7.	The support provided to me by the subcontractor or agency that hired me as a trainer.	1	2	3	4	5
8.	The rooms in which training takes place.	1	2	3	4	5
9.	My experiences with parents or as a parent.	1	2	3	4	5
10.	The support provided to me by the field representatives from the Center for Urban Studies at Wayne State University.	1	2	3	4	5
11.	The concentrated time period for training.	1	2	3	4	5

12. Please list any other strengths not listed above, that you think are likely to be helpful to your training sessions.

____

____

____

____

____

TP-6/80

II. Below are listed some areas that might be considered barriers to success in your training sessions. Please read each statement and circle the number that best describes how likely it is that this barrier will be a problem in your training.

	Not at all likely 1	2	3	4	Extremely likely 5
1. Lack of resource materials (i.e., books, films) appropriate to the topics for training sessions.	1	2	3	4	5
2. Lack of resource materials (i.e., books, films) appropriate to the skill and education level of participants.	1	2	3	4	5
3. Attitude differences between myself and the participants about what is best for children.	1	2	3	4	5
4. Misinformation, myths and superstitions participants have about children and their care.	1	2	3	4	5
5. "Burn-out" of participants who have lost enthusiasm and energy for their work.	1	2	3	4	5
6. Participants rejecting suggestions because they require too much effort to apply on the job.	1	2	3	4	5
7. Participants rejecting suggestions due to lack of money in their centers or homes to implement them.	1	2	3	4	5
8. Mistrust among participants.	1	2	3	4	5
9. Mistrust between trainer and participants.	1	2	3	4	5
10. Hostility from one or two persons who are vocal in or out of the sessions about their opinions.	1	2	3	4	5
11. Lack of reading and writing skills for some participants.	1	2	3	4	5

12. Please list any other barriers not listed above, that you think are likely to be problems for your training sessions.

THANK YOU

Center for Urban Studies
Wayne State University
DAY CARE PROVIDER TRAINING PROJECT

Mother's Maiden Name: ____________________

Date: ____________________

Training Session Location: ____________________

TRAINER PERCEPTION SURVEY

1. Below are listed some strengths that your training sessions may have had that aided in their success. Please read each statement and circle the number that best describes how helpful each strength listed was to your training sessions.

		Not at all helpful				Extremely helpful
		1	2	3	4	5
1.	My educational background.	1	2	3	4	5
2.	My previous day care experience.	1	2	3	4	5
3.	My contacts in the local community.	1	2	3	4	5
4.	The resource materials (i.e., books, films) that I used.	1	2	3	4	5
5.	The support and enthusiasm derived from group discussion and questions.	1	2	3	4	5
6.	My skill in talking with and understanding people.	1	2	3	4	5
7.	The support provided to me by the subcontractor or agency that hired me as a trainer.	1	2	3	4	5
8.	The rooms in which training took place.	1	2	3	4	5
9.	My experiences with parents or as a parent.	1	2	3	4	5
10.	The support provided to me by the field representatives from the Center for Urban Studies at Wayne State University.	1	2	3	4	5
11.	The concentrated time period for training.	1	2	3	4	5

Please list any other strengths not listed above that you think were helpful to your training sessions.

TP-6/80

II. Below are listed some areas that might have been barriers to success in your training sessions. Please read each statement and circle the number that best describes how much each barrier listed was a problem for your training.

		Not at all a problem				Extremely problematic
		1	2	3	4	5
1.	Lack of resource materials (i.e., books, films) appropriate to the topics for training sessions.	1	2	3	4	5
2.	Lack of resource materials (i.e., books, films) appropriate to the skill and education level of participants.	1	2	3	4	5
3.	Attitude differences between myself and the participants about what is best for children.	1	2	3	4	5
4.	Misinformation, myths and superstitions participants have about children and their care.	1	2	3	4	5
5.	"Burn-out" of participants who have lost enthusiasm and energy for their work.	1	2	3	4	5
6.	Participants rejecting suggestions because they require too much effort to apply on the job.	1	2	3	4	5
7.	Participants rejecting suggestions due to lack of money in their centers or homes to implement them.	1	2	3	4	5
8.	Mistrust among participants.	1	2	3	4	5
9.	Mistrust between trainer and participants.	1	2	3	4	5
10.	Hostility from one or two persons who are vocal in or out of the sessions about their opinions.	1	2	3	4	5
11.	Lack of reading and writing skills for some participants.	1	2	3	4	5

Please list any other barriers not listed above that you think were problems for your training sessions.

THANK YOU!

Center for Urban Studies
Wayne State University
DAY CARE PROVIDER TRAINING PROJECT

Mother's Maiden Name: ______________________

Date: ______________________

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Trainer Training Session Description Form

We need for you to describe each training session after it has taken place. Please fill this out within an hour or two after the training session.

STEP 1: Check the major topics covered in today's training session.

( ) Topic #1: Human growth and development
( ) Topic #2: Health
( ) Topic #3: Nutrition
( ) Topic #4: Safety
( ) Topic #5: Education process
( ) Topic #6: Play
( ) Topic #7: Discipline
( ) Topic #8: Physical Space
( ) Topic #9: Programming
( ) Topic #10: Interpersonal skills with staff and families
( ) Topic #11: Curriculum content
( ) Topic #12: Working with parents
( ) Topic #13: Confidentiality
( ) Topic #14: Legal Issues
( ) Topic #15: Understanding self as caregiver
( ) Topic #16: Other subjects specific to particular needs: ______________________
____

STEP 2: Type of Format Check all formats that you used today.	STEP 3: Topic Number For each format checked, record the appropriate topic number(s) from above.	STEP 4: About how long did each type of format last? (Circle one number) Just a few minutes	About ½ hour	More than ½ hour
( ) 1. Presentation by trainer (lecture or talk).	______	1	2	3
( ) 2. Special outside speaker (lecture or talk).	______	1	2	3
( ) 3. Discussion by participants in entire group.	______	1	2	3
( ) 4. Discussions by participants in small groups. (How many in each group? ______)	______	1	2	3
( ) 5. Individual consultations of trainer with each participant.	______	1	2	3
( ) 6. Film or videotape.	______	1	2	3
( ) 7. Observing actual children who were present.	______	1	2	3
( ) 8. Role playing or pretending to be a child or teacher.	______	1	2	3
( ) 9. Making toys, learning materials or food.	______	1	2	3

STEP 5:

10. Some training sessions work out well and others do not. Overall, how would you rate the success of this session? (circle one number)

Very Unsuccessful	Unsuccessful	Successful	Very Successful
1	2	3	4

11. What could have been done to improve today's session? ______________________
____
____
____

12. What was the best thing about this session? ______________________
____
____
____

If you have any other comments, use the other side of this sheet.

TT-6/80

THANK YOU.

(Contrast Group - Mailed)

Center for Urban Studies - Wayne State University
DAY CARE PROVIDER TRAINING PROJECT

County: ______________________ Today's Date: ______________

PLEASE CHECK (√):

1. Where do you work?
( ) 1. Family Day Care Home
( ) 2. Child Care Center

2. Did you want to receive child care provider training this summer (June - September)?
( ) 1. Yes
( ) 2. NO

3. Did you attend any day care provider training classes this summer (June - September)?
( ) 1. Yes
( ) 2. No

IF YES:

4. What group, agency, or institution offered your training? (For example: Family Day Care Council)
____

5. Where did your class meet? (For example: Smithfield High School)
____

Please do not complete the survey. Mail this sheet and the blank survey back to us in the stamped, self-addressed envelope enclosed.

STOP

IF NO:

6. What were some of the reasons you did not attend training classes?
____
____
____
____

Please complete the following survey and mail it to us in the stamped envelope enclosed as soon as possible.

GO ON

(Pages 1-5 are the same as pages 1-5 of the Caregiver Survey)

THANK YOU

PART IV: Please check (✓) the responses that apply to you.

1. What age groups do you work with right now in your current job? (Check all that apply.)

   ( ) under 1 year old
   ( ) 1 to 2½ years old
   ( ) 2½ to 5 years old
   ( ) over 5 years old

2. How many hours do you work each week? ____________________

3. In what kind of area is your family day care home or center? (Please check one.)

   ( ) 1. Rural or small town
   ( ) 2. Small city
   ( ) 3. Medium-sized city
   ( ) 4. Suburb
   ( ) 5. Large city

4. How long have you worked in child care, including your present job?

   _____ years _____ months

5. What different kinds of experiences have you had in child care? Check all that apply and indicate how long each experience lasted, including your current job.

What kind of experience	How many years or months did it last?
( ) 1. Day Care Center Staff (teacher, caregiver)	_____ years _____ months
( ) 2. Day Care Center Aide	_____ years _____ months
( ) 3. Day Care Center Director	_____ years _____ months
( ) 4. Day Care Home Provider	_____ years _____ months
( ) 5. Day Care Home Aide	_____ years _____ months
( ) 6. Other ______________________	_____ years _____ months

6. Please check below any kinds of child care training you have had. (Check all that apply.)

   ( ) 1. High school courses (early childhood education, child development, child care)
   ( ) 2. College courses for college credit (early childhood education, child development, child care)
   ( ) 3. Conferences or Workshops
   ( ) 4. Child Development Associate (CDA) certification
   ( ) 5. Other - please specify: ____

7. What is your sex? ( ) 1. Male ( ) 2. Female

8. What age group are you in? (Please check one)

- ( ) under 21 years old
- ( ) 21 to 30 years old
- ( ) 31 to 40 years old
- ( ) 41 to 50 years old
- ( ) over 50 years old

9. What education do you have? (Check the highest one that applies to you)

- ( ) 1. Elementary school (highest grade completed: _____)
- ( ) 2. Some high school (highest grade completed: _____)
- ( ) 3. High school diploma or G.E.D.
- ( ) 4. Some college (number of years: _____)
- ( ) 5. Associate of Arts (2 year college degree)
- ( ) 6. Bachelor (4 year college degree - B.A. or B.S.)
- ( ) 7. Some masters level credits (number of credits: _____)
- ( ) 8. Masters (M.A., M.S., etc.)

10. Please check your ethnic background. (Please check one)

- ( ) 1. Black/Afro-American
- ( ) 2. White
- ( ) 3. Hispanic
- ( ) 4. Native American Indian
- ( ) 5. Other - please specify:________________________

Thank you for your help. Please mail this survey back to us in the self-addressed, stamped envelope.

Center for Urban Studies
Day Care Provider Training Project
5229 Cass
Wayne State University
Detroit, MI 48202

Instructions for Observation of Home Providers

This evaluation has been designed to be used as an observational instrument. The long form is to be studied before going into the day care homes, so the evaluator is very familiar with the items to be observed. The shortened form can be taken into the homes and referred to by the evaluator, but should not be filled out at the time of observation. Immediately upon leaving the day care home, the evaluator should fill out this form, adding specific comments at the bottom.

During the observations, the evaluator should encourage the provider to go about his/her regular day. Those areas which cannot be directly observed should be ascertained through a conversational interview; the provider should not feel they are being scrutinized.

Some terms used in the forms need clarification.

"playthings" - do not have to be items designed specifically as "toys" for children, but can include household items, boxes, etc.

"available" - does not have to be directly accessible by children, but is in home and used regularly.

"area of activity" - can be simply different ends of a room, or more defined; the opposite would be various materials scattered throughout.

"physical punishment; restraint" - spanking, jerking, pulling harshly, pushing.

"teaching concepts" - can be informal; pointing out colors in room, counting number of chairs, describing various shapes that can be seen.

"adult- vs. child-directed activities" the adult always, or typically leads the children to activities, instructs them as to what to do, etc., as opposed to children discovering and choosing their own activities.

"quiet /active play" - a balance between those activities requiring running, jumping, climbing, etc. and activities such as art, puzzles, reading, cooking, etc.

The scoring system to be used is either "1" or "2". A "1" indicates a lesser degree of either an event/activity or materials, with "2" representing a high degree of activity or materials. (Some items are reverse-scored later so that 1=inadequate and 2=adequate for each item).

Some items may not be quantity of materials, but the degree to which this activity or item occurs can be represented using the "1" or "2" scoring.

The space for comments at the end of the short form is to be used for any specific additional observations made, or to note any inconsistencies of what has been seen and what provider has stated.

	Low Amount	High Amount
I. Environment		
A. Areas of Activity		
1. accessible hook and space		
2. "special place"		
3. divided areas		
4. plants		
5. pets		
B. Materials		
1. numbers equal to children		
2. age - appropriate		
3. small motor playthings		
4. large motor playthings		
5. cognitive materials [2]		
6. art materials		
7. musical materials [2]		
8. child - sized table/chairs		
II. Curriculum		
1. daily schedule [1]		
2. activities:		
a. adult - directed > a balance is desirable		
b. child - directed > a balance is desirable		
3. active and quiet play		
4. "messy" activities [1]		
5. outdoor space		
6. children help with meals [1]		
7. teaching concepts		
8. self - help skills		
9. time spent:		
a. TV [3]		
b. outside		
c. naps [1]		
III. Interpersonal Skills		
A. Discipline		
1. rules explained		
2. children work out problems		
3. negative feelings expressed		
a. to other children		
b. to adult(s)		
4. physical punishment/restraint [1,3]		
5. age - appropriate rules		
6. provider shouts/yells [3]		
B. Communication		
1. frequent interaction with children		
2. talk at eye-level		
3. warmth conveyed:		
a. verbally		
b. physically		
4. eats with children:		
a. snacks [1]		
b. lunch [1]		

	Low Amount	High Amount
III. (cont.)		
5. verbal expression encouraged		
6. children interact alone		
7. special needs recognized		
8. choices encouraged		
9. provider interacts with parents [1]		
IV. Health and Safety		
A. Physical Safety		
1. obvious hazards[3]		
2. First Aid supplies[1]		
B. Health		
1. parents called ill child[1]		
2. isolation of ill child[1]		
C. Nutrition		
1. nutritional snacks[1]		
2. nutritional lunches[1]		
V. Record Keeping		
1. attendance records[1]		
a. all children		
b. DSS children		
2. medical records[1]		
3. financial records[1]		

Additional Comments:

---

[1] verbal report

[2] verbal report and observation

[3] a score of "1" is desirable. These items are reverse-scored after the observation

APPENDIX B

BACKGROUND PROJECT DATA

1. Project Officer's letter to Day Care Providers (May 7, 1980)
2. Provider Sign-Up Sheet
3. County Checklist of Child Care Centers and Day Care Homes
4. List of members of The Day Care Provider Training Project Advisory Committee (Project Year One)
5. List of members of The Training Task Force of the Day Care Advisory Committee to the Michigan Department of Social Services, 1975

JUL 18 1980

A-27

STATE OF MICHIGAN

WILLIAM G. MILLIKEN, Governor

DEPARTMENT OF SOCIAL SERVICES

300 S. CAPITOL AVENUE, LANSING, MICHIGAN 48926

JOHN T. DEMPSEY, Director

May 7, 1980

DEAR DAY CARE PROVIDER:

We are pleased to announce that the Michigan Department of Social Services (MDSS) will be offering training for family day care home operators and child care center staff this summer who are currently caring for MDSS children (or plan to upon completion of the training). The Center For Urban Studies, Wayne State University (CUS/WSU) will administer the training project this year. In turn, CUS/WSU will deliver the training through subcontracts with local training agencies (from about June 15th through September 30, 1980). Most training expenses will be paid for by the training Project. For planning purposes, we need to know who is interested in taking the training this year, and what the training should cover. PLEASE COMPLETE AND SEND (in the enclosed pre-paid, self-addressed envelope) THE ATTACHED GOLDENROD SIGN-UP SHEET BY TUESDAY, May 27, 1980.

Twenty hours of participation will be required to earn a training certificate. The training will include some of the following subjects:

- Human growth and development of children.
- Health and protection needs.
- Learning process at different stages of development.
- Play
- Discipline.
- Planning and scheduling a balanced day.
- Setting-up a playroom and selecting toys and equipment.
- The what and how of teaching children.
- Working with parents.
- Working with other providers and staff of diverse backgrounds and values.
- Confidentiality - what you can do and what you cannot.
- Legal rights and responsibilities of providers.
- Other subjects on direct caregiving.

You and the other providers, in cooperation with the training agency, will decide which subjects will be covered in greater depth. The average training group will be about 20 providers. The trainer will try to schedule the training at times that are most convenient for providers. Where possible, it will be held in or near your community. Due to limited funding, we cannot guarantee that training will be available in all communities. The numbers of providers who complete and send in the goldenrod Sign-Up Sheet will help determine where the training will be offered this year.

If your local training agency (yet to be selected) signs a contract to deliver the training, you will probably be contacted sometime in June or July about scheduling and further information. Training start-up and ending dates may vary. If you have any

(OVER)

comments or suggestions about the training Project, please feel free to contact the Project Director. Her address and telephone number are: Louise L Sally Brown, Director, Day Care Provider Training Project, Center for Urban Studies, Wayne State University, Detroit, Michigan 48202, 313-577-2208. Thank you. Have a good summer.

Sincerely,

Roger C. Nelson

Roger C. Nelson
Social Services Training Division
6545 Mercantile Way, Suite #9
Lansing, Michigan 48910

1980 DAY CARE PROVIDER TRAINING PROJECT

A-29

PROVIDER SIGN-UP SHEET

DEAR PROVIDER: 5/7/80

PLEASE COMPLETE AND SEND (in the pre-paid, self-addressed envelope) this "Sign-Up" sheet by May 27, 1980 to:

Social Services Training Division
Department of Social Services
6545 Mercantile Way, Suite #9
Lansing, Michigan 48910

Attention: Roger Nelson

PLEASE PRINT:

NAME: ______________________ ADDRESS: ______________________

COUNTY: ______________________ ______________________

LICENSE #: ______________________ TELEPHONE NO. ______________________

CHECK ☑ TYPE: ☐ FAMILY HOME ☐ CENTER

PLEASE CHECK ☑ :

Do you want training? Check ☐ Yes ☐ No ☐ Not Sure.

If you have staff, do you want them to have training? Check ☐ Yes ☐ No ☐ Not Sure.

If "yes", how many staff? ______________

Please check ☑ below which subject areas you want training to include:

___ Human growth and development of children.
___ Health and protection needs.
___ Learning process at different stages of development.
___ Play.
___ Discipline.
___ Planning and scheduling a balanced day.
___ Setting-up a playroom and selecting toys and equipment.
___ The what and how of teaching children.
___ Working with parents.
___ Working with other providers and staff of diverse backgrounds and values.
___ Confidentiality - what you can do and what you cannot.
___ Legal rights and responsibilities of providers.
___ Other subjects on direct caregiving.

You will be notified if and when training will be offered in or near your community.

COMMENTS OR SUGGESTIONS?

Thank you!

JUL 1 0 1980

COUNTY CHECKLIST (by County Code)
Michigan Department of Social Services

Item No.	Rev. Date	Requestor's Name
		Page 1 of 3 Pages

Requesting Date	Title of Item
	(A-30) May, 1980

Remarks:

SUBJECT: 1980 Day Care Provider Training Project

REGARDING: Survey of Providers Sent 5/7/80

CHILD CARE CENTERS BY COUNTY

ROGER NELSON, SSTD
7/10/80

Given to WSU 7/10/80

RESULTS:

			NUMBER OF CENTERS		CAPACITY				NUMBER OF CENTERS		CAPACITY	
1	Alcona	AL	3	0	55	43	Lake	LA	1	0	50	
2	Alger	AG	3	0	60	44	Lapeer	LP	9	0	235	
3	Allegan	AE	10	1/1/0	594	45	Leelanau	LE	6	1/0/0	210	
4	Alpena	AP	12	0	199	46	Lenawee	LN	16	3-11/0/0	578	
5	Antrim	AN	8	0/0/1	174	47	Livingston	LI	17	2-5/0/0	493	
6	Arenac	AR	4	0	133	48	Luce	LU	2	0	40	
7	Baraga	BG	3	0	57	49	Mackinac	MA	5	0	95	
8	Barry	BA	10	1-33/0/0	234	50	Macomb	MC	144	9-66/1/1	4,263	
9	Bay	BY	24	0	1,149	51	Manistee	MN	4	0	135	
10	Benzie	BE	5	1-10/0/0	96	52	Marquette	MR	10	3-20/1/0	432	
11	Berrien	BN	33	5-49/2/0	1,345	53	Mason	MS	5	0	130	
12	Branch	BR	10	1-5/1/0	316	54	Mecosta	MT	7	0	175	
13	Calhoun	CA	37	6-94/1/0	1,257	55	Menominee	ME	4	0	84	
14	Cass	CS	3	1-3/0-1/5	105	56	Midland	MI	27	2-7/2/4-5	855	
15	Charlevoix	CH	6	1/0-1/0	115	57	Missaukee	MR	2	0	44	
16	Cheboygan	CE	6	2-5/0/0	110	58	Monroe	MO	23	2-4/0/0	836	
17	Chippewa	CP	9	1-7/0/1	189	59	Montcalm	MM	13	0	319	
18	Clare	CL	6	1-3/0/0	150	60	Montmorency	MY	5	0	105	
19	Clinton	CT	11	1/0/0	248	61	Muskegon	MU	48	5-26/0-1/0	1,178	-1
20	Crawford	CR	2	0	40	62	Newaygo	NE	10	1-21/0/0	314	
21	Delta	DE	6	2-7/0/0-1	175	63	Oakland	OC	284	14-94/3-10/	9,730	1-4
22	Dickinson	DI	0	0	0	64	Oceana	OE	8	0	300	
23	Eaton	EA	20	1/0/0	565	65	Ogemaw	OG	5	1-4/0/1	115	
24	Emmet	EM	7	0	189	66	Ontonagon	ON	4	0	75	
25	Genesee	GC	102	12-94/1-2/1	3,079	67	Osceola	OS	5	0	125	
26	Gladwin	GL	2	0	47	68	Oscoda	OD	1	0	20	
27	Gogebic	GO	4	1-18/0/0	72	69	Otsego	OT	4	1-6/0/0	95	
28	Gd. Traverse	GR	15	3-18/0/0	435	70	Ottawa	OW	34	4-43/1-1/0	1,055	
29	Gratiot	GT	12	1-26/0/0	359	71	Presque Isle	PR	5	0	116	
30	Hillsdale	HI	6	0	158	72	Roscommon	RO	5	0	100	
31	Houghton	HO	8	1-5/0/0	241	73	Saginaw	SA	70	16-96/0-1/0	2,415	
32	Huron	HU	5	0	85	74	St. Clair	SC	30	0/1/0	719	
33	Ingham	IC	87	13-92/2-4/1	2,879	75	St. Joseph	SJ	20	1-4/0/0	522	
34	Ionia	IO	12	0/0/1	321	76	Sanilac	SN	11	1-6/0/0	277	
35	Iosco	IS	4	0	100	77	Schoolcraft	SO	3	0	55	
36	Iron	IR	0	0	0	78	Shiawassee	SH	12	2-12/0-1/0	393	
37	Isabella	IB	9	0	283	79	Tuscola	TU	12	0/2/1	297	
38	Jackson	JA	39	8-55/0/0	1,255	80	Van Buren	VB	19	3-30/0-1/0	628	-
39	Kalamazoo	KA	65	10-43/0-1/1	1,883	81	Washtenaw	WA	89	12-78/1-9/3	3,414	
40	Kalkaska	KL	2	0	38	82	Wayne	WC	526	72-475/1-	22,711	10/2-6
41	Kent	KE	125	12-40/0-6/1	4,031	83	Wexford	WE	6	0	163	
42	Keweenaw	KW	0	0	0							

KEY: 12-40/0-6/1 - - - - 1 "no" response
12="yes" responses; 40="yes" trainees involved
0="not sure" responses; 6="not sure" trainees

TOTAL	2,270	76,809

SUMMARY: (Centers)
245 "yes" responses involving 1,630 trainees.
21 "not sure" responses involving 61 trainees.
25 "no" responses involving 35 trainees +.

DSS-69 (Rev. 11-77) Previous editions may be used.

COUNTY CHECKLIST (by County Code)
Michigan Department of Social Services

Item No.

Rev. Date

Requestor's Name
Page 2 of 3 Pages

Requesting Date

Title of Item
(A-31) May, 1980

Remarks:

ROGER NELSON, SSTD
7/10/80

DAY CARE HOMES
BY COUNTY

REGARDING: Survey of Providers
Sent 5/7/80

RESULTS:

			FAMILY DAY CARE HOMES			GROUP DAY CARE HOMES		TOTAL	
			NUMBER		CAPACITY	NUMBER	CAPACITY	NUMBER	CAPACITY
1	Alcona	AL	8	1/1/0	34			8	34
2	Alger	AG	18	0	55			18	55
3	Allegan	AE	112	3/5/12	539			112	539
4	Alpena	AP	50	3/4/4	180			50	180
5	Antrim	AN	48	2/0/2	222			48	222
6	Arenac	AR	16	1/0/1	59			16	59
7	Baraga	BG	5	1/0/0	13			5	13
8	Barry	BA	50	4-7/1/2	212			50	212
9	Bay	BY	55	4/2/7	180			55	180
10	Benzie	BE	15	1/0/0	77			15	77
11	Berrien	BN	290	12-13/8/15	1,311			290	1,311
12	Branch	BR	51	5/1/5	252			51	252
13	Calhoun	CA	206	5/6/7	917			206	917
14	Cass	CS	82	4/2/1	381			82	381
15	Charlevoix	CH	57	1/2/2	269			57	269
16	Cheboygan	CE	42	1/1/3	186			42	186
17	Chippewa	CP	74	1/1/3	280			74	280
18	Clare	CL.	9	0	41			9	41
19	Clinton	CT	75	1/5/4	327			75	327
20	Crawford	CR	24	2/1/2	123			24	123
21	Delta	DE	43	5/5/8	159			43	159
22	Dickinson	DI	43	1/2/3	105			43	105
23	Eaton	EA	166	8/6/21	758			166	758
24	Emmet	EM	54	4-5/3/1	267			54	267
25	Genesee	GC	612	44-55/14/	2,530-	31		612	2,530
26	Gladwin	GL	29	3-4/1/2	131			29	131
27	Gogebic	GO	26	2/0/1	96			26	96
28	Gd. Traverse	GR	308	26/11/6	1,368			308	1,369
29	Gratiot	GT	76	2/3/2	333			76	333
30	Hillsdale	HI	60	2/2/2	278			60	278
31	Houghton	HO	'20	0	53			20	53
32	Huron	HU	36	6-7/3/1	151			36	151
33	Ingham	IC	618	29-30/31/	2,813	33		618	2,813
34	Ionia	IO	56	4/3/1	246			56	246
35	Iosco	IS	33	0	138			33	138
36	Iron	IR	13	1/1/0	55			13	55
37	Isabella	IB	71	6/4/4	346			71	346
38	Jackson	JA	307	21-22/7/9	1,393			307	1,393
39	Kalamazoo	KA	784	18/8/24	3,101			784	3,101
40	Kalkaska	KL	26	2/1/0	127			26	127
41	Kent	KE	504	26/17/27	1,822			504	1,822
42	Keweenaw	KW		0					

COUNTY CHECKLIST (By County Code)
Michigan Department of Social Services

Ref. No.	Rev. Date	Requestor's Name
		Page 3 of 3 Pages

Requesting Date	Title of Item
	(A-32) May, 1980 pg 2

Remarks:

DAY CARE HOMES

BY COUNTY

ROGER NELSON, SSTD
7/10/80

REGARDING: Survey of Providers
Sent 5/7/80

RESULTS:

			FAMILY DAY CARE HOMES				GROUP DAY CARE HOMES		TOTAL	
			NUMBER		CAPACITY		NUMBER	CAPACITY	NUMBER	CAPACITY
43	Lake	LA	15	0	55				15	55
44	Lapeer	LP	125	6/2/8	504				125	504
45	Leelanau	LE	36	2/3/1	171				36	171
46	Lenawee	LN	113	9-10/2/4	530		1	12	114	542
47	Livingston	LI	74	1/4/2	327				74	327
48	Luce	LU	14	1/0/0	56				14	56
49	Mackinac	MA	10	0/1/0	52				10	52
50	Macomb	MC	400	29/11/12	1,647				400	1,647
51	Manistee	MN	31	0/1/2	116				31	116
52	Marquette	MR	123	5/3/3	425				123	425
53	Mason	MS	36	1/0/0	119				36	119
54	Mecosta	MT	149	7/0/4	608				149	608
55	Menominee	ME		0						
56	Midland	MI	206	7/3/4	871				206	871
57	Missaukee	MR	9	0/1/1	50				9	50
58	Monroe	MO	70	4/2/3	290				70	290
59	Montcalm	MM	38	1/2/1	152				38	152
60	Montmorency	MY	19	0	87				19	87
61	Muskegon	MU	203	19-20/9/13	749				203	749
62	Newaygo	NE	35	4/1/0	162				35	162
63	Oakland	OC	526	48-51/11/	2,507	17	1	12	527	2,519
64	Oceana	OE	44	3/2/4	156				44	156
65	Ogemaw	OG	24	0/1/0	89				24	89
66	Ontonagon	ON	2	0	2				2	2
67	Osceola	OS	32	1/1/1	154				32	154
68	Oscoda	OD	9	2-3/0/1	31				9	31
69	Otsego	OT	39	2/2/1	154				39	154
70	Ottawa	OW	222	11-13/10/9	793				222	793
71	Presque Isle	PR	12	2/1/1	40				12	40
72	Roscommon	RO	28	0/1/0	98				28	98
73	Saginaw	SA	358	19-22/8/18	1,383				358	1,383
74	St. Clair	SC	120	7/2/10	486				120	486
75	St. Joseph	SJ	90	1/5/5	444				90	444
76	Sanilac	SN	63	1/1/4	254				63	254
77	Schoolcraft	SO		0						
78	Shiawassee	SH	71	4/4/3	305				71	305
79	Tuscola	TU	79	3/2-2/4	291				79	291
80	Van Buren	VB	85	10/2/5	359				85	359
81	Washtenaw	WA	444	40-48/10-11	2,037	/14			444	2,037
82	Wayne	WC	942	109-123/	4,158	14/25			942	4,158
83	Wexford	WE	70	2/1/2	261				70	261
TOTAL			10,138		42,901		2	24	10,140	42,925

SUMMARY: (Homes)
622 "yes" responses involving 676 trainees.
285 "not sure" responses involving 286 trainees.
428 "no" responses involving 428 trainees.

DSS-49 (Rev. 11-77) Previous editions may be used.

The Day Care Provider Training Project
Advisory Committee
(Project Year One)

Pearl Axelrod, Chairperson
University of Michigan School
of Education (retired)
Day Care Consultant
Chairperson, Advisory Committee
on Day Care to the Michigan
Department of Social Services

Sandra Carden
President, Michigan Association
of Child Care Administrators
Legislative Secretary, Metro
Detroit Association for the
Education of Young Children

Sharon Elliott
Associate Professor, College of
Education, Wayne State
University
President, Michigan Association
for the Education of Young
Children

Bill Hankins
Day Care Services Program Manager,
Michigan Department of Social
Services

Judy Hollister
Assistant Director of Area
Agencies on Aging Association
of Michigan

Sally Hruska
Headstart Teacher
Trainer, Day Care Provider
Training Project

Laura Humphreys
Chairperson, Midland County Family
Day Care Association

Tommie Evans Lee
Licensing Consultant, Division
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Michigan Department of Social
Services

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Project Officer, Social Services
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Michigan Department of Social
Services

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Project Office Supervisor, Social
Services Training Division, Office
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Michigan Department of Social
Services

Aaron Pitts
Friends of Headstart
Black Graphics International

Tito Reyes
Early Childhood Consultant
Child Development Associate (CDA)
Representative

Janine Stephenson
Administrative Assistant, Division
of Child Day Care Licensing,
Michigan Department of Social
Services

The Training Task Force of the Day Care Advisory Committee to the Michigan Department of Social Services

1975

Members of Training Task Force

Ms. Evelyn Linden, Chairperson
Day Care Consultant to United Community
Services of Metropolitan Detroit
Former Director of Franklin-Wright
Day Care Center

Ms. Pearl Axelrod
Special Assistant to the Dean
University of Michigan School of Education
Coordinator: Day Care Directors and Centers
Staff Training

Ms. Anne Brooks
Consumer Representative
Community Worker for Children's Aid
Society of Metropolitan Detroit

Dr. Esther Callard
Department Chairperson: Family and
Consumer Resources
Liberal Arts
Wayne State University

Mr. Michael Hudson
V-Ch. Michigan State 4-C's Council
Former Administrator, Community Child
Care & Development Association
Lansing, Michigan

Mr. Robert McConnell
V-Ch. Day Care Advisory Committee
Coordinator of Public Assistance Programs
Michigan Vocational Rehabilitation Service

Resource Persons to the Task Force

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Division of Day Care Services
Michigan Department of Social Services

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Michigan Department of Social Services

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Program Specialist/Day Care Services
Region 9
Michigan Department of Social Services

Ms. Sally Brown
Executive Coordinator
Detroit, Wayne County 4-C's

Ms. Sue Brook
Coordinator
Michigan State 4-C's

Ms. Jackie Wood
Project Assistant, Family Day Care
Home Licensing
Michigan Department of Social Services

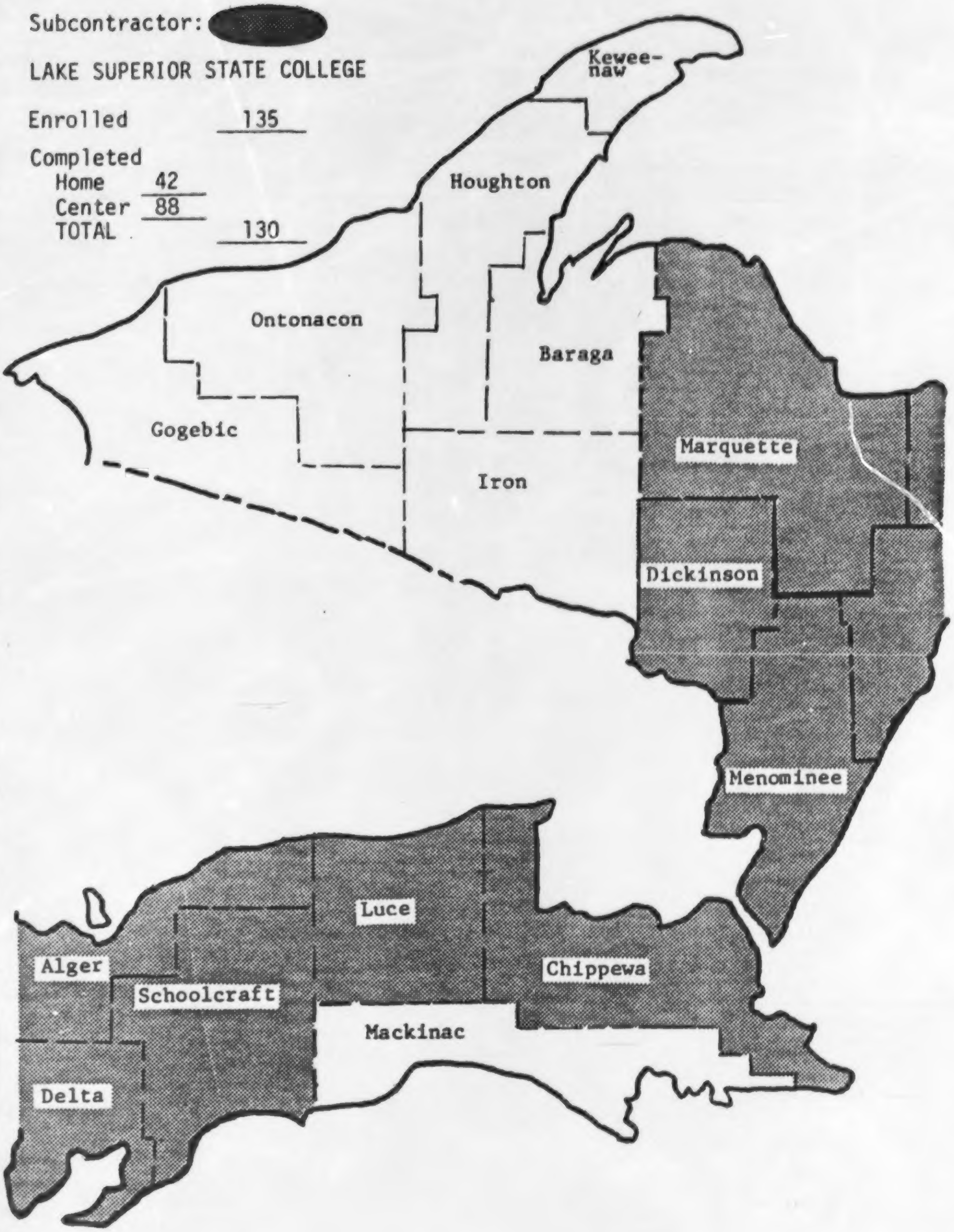
APPENDIX C

ENROLLMENT MAPS AND LONG DATA TABLE

1. Map A: Counties in Which the Subcontractor LSSC Offered Training
2. Map B: Counties in Which Specific Subcontractors Offered Training
    - Alpena Community College
    - Grand Traverse 4-C
    - Kirtland Community College
3. Map C: Counties in Which Specific Subcontractors Offered Training
    - Alma Day Care
    - Delta College
    - Saginaw Intermediate School District
4. Map D: Counties in Which Specific Subcontractors Offered Training
    - Grand Valley, Kirkhof College
    - Kalamazoo Valley Community College
5. Map E: Counties in Which Specific Subcontractors Offered Training
    - F.A.C., Wayne State University
    - Family Day Care Council
    - Mercy College
    - University of Michigan
    - Wayne County Community College
6. Map F: Counties in Which the Subcontractor Mott Offered Training
7. Table 8-A: Perceived Training Needs for Competency Topics

MAP A

COUNTIES IN WHICH THE SUBCONTRACTOR LSSC OFFERED TRAINING



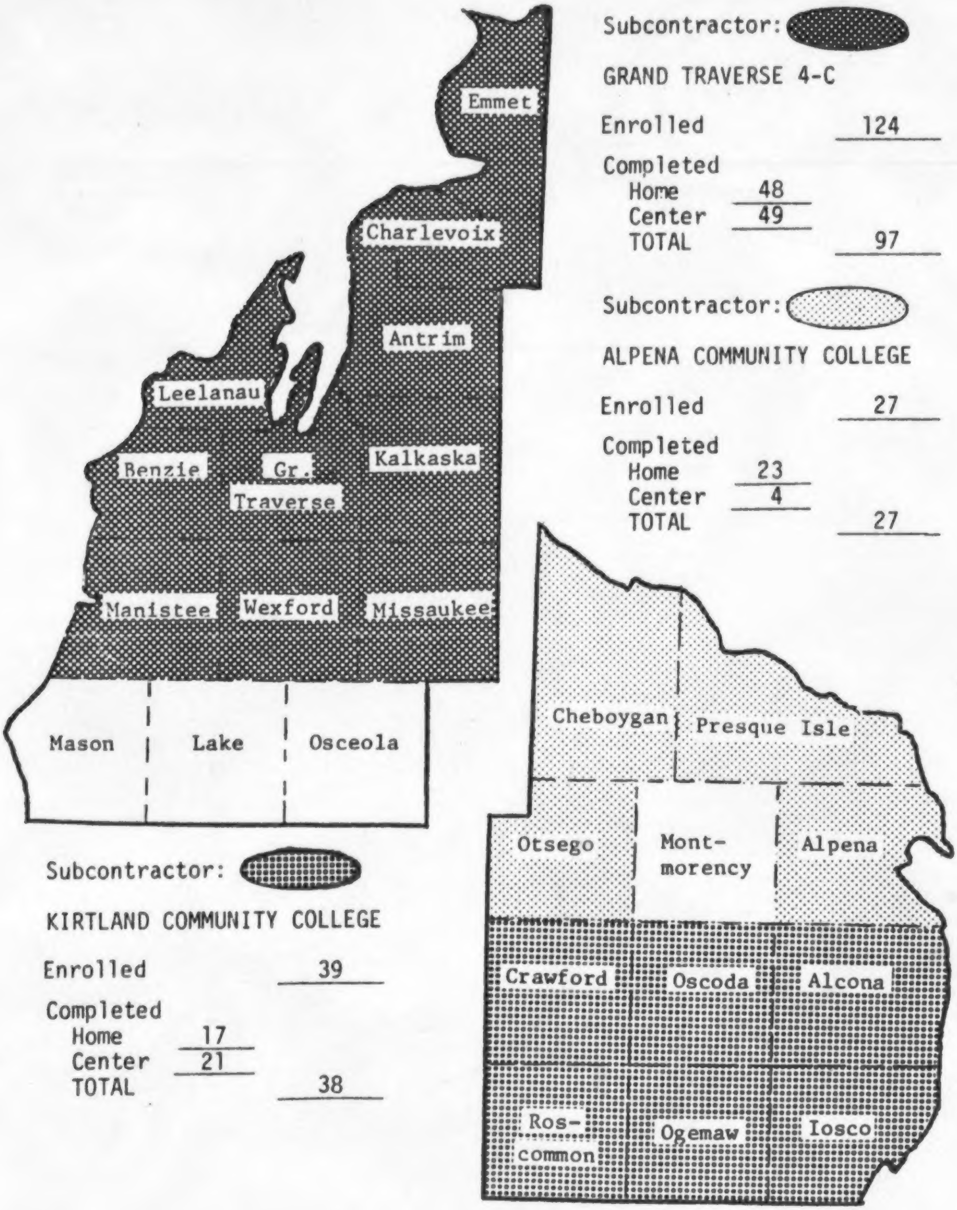
Subcontractor: ●

LAKE SUPERIOR STATE COLLEGE

Enrolled		135
Completed		
Home	42	
Center	88	
TOTAL		130

Keweenaw
Houghton
Ontonacon
Baraga
Gogebic
Iron
Marquette
Dickinson
Menominee
Luce
Alger
Chippewa
Schoolcraft
Mackinac
Delta

MAP B
COUNTIES IN WHICH SPECIFIC SUBCONTRACTORS OFFERED TRAINING


Emmet
Charlevoix
Antrim
Leelanau
Benzie
Gr. Traverse
Kalkaska
Manistee
Wexford
Missaukee
Mason
Lake
Osceola
Cheboygan
Presque Isle
Otsego
Mont-morency
Alpena
Crawford
Oscoda
Alcona
Ros-common
Ogemaw
Iosco

Subcontractor: ●

GRAND TRAVERSE 4-C

Enrolled		124
Completed		
Home	48	
Center	49	
TOTAL		97

Subcontractor: ○

ALPENA COMMUNITY COLLEGE

Enrolled		27
Completed		
Home	23	
Center	4	
TOTAL		27

Subcontractor: ▨

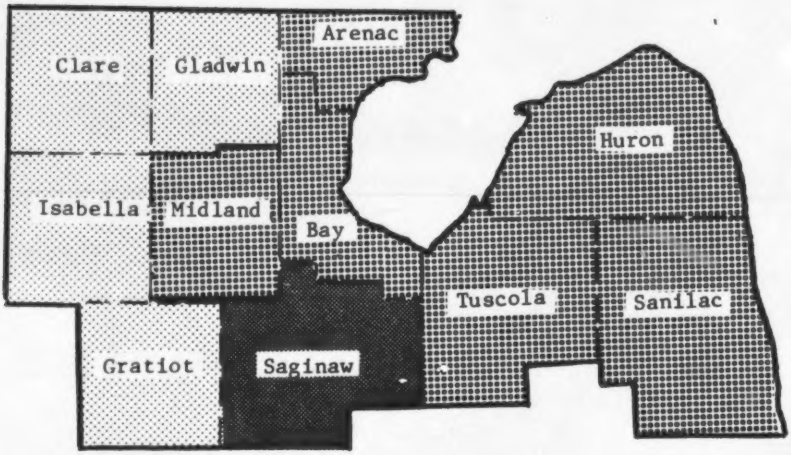
KIRTLAND COMMUNITY COLLEGE

Enrolled		39
Completed		
Home	17	
Center	21	
TOTAL		38

MAP C

COUNTIES IN WHICH SPECIFIC SUBCONTRACTORS OFFERED TRAINING

A-38


Clare
Gladwin
Arenac
Huron
Isabella
Midland
Bay
Tuscola
Sanilac
Gratiot
Saginaw

Subcontractor:

ALMA DAY CARE

Enrolled		96
Completed		
Home	25	
Center	48	73
TOTAL		

░ Alma Day Care
Saginaw Intermediate

▒ Delta College

▓ Delta College
Saginaw Intermediate

Subcontractor:

SAGINAW INTERMEDIATE SCHOOL DISTRICT

Enrolled		108
Completed		
Home	94	
Center	11	
TOTAL		105

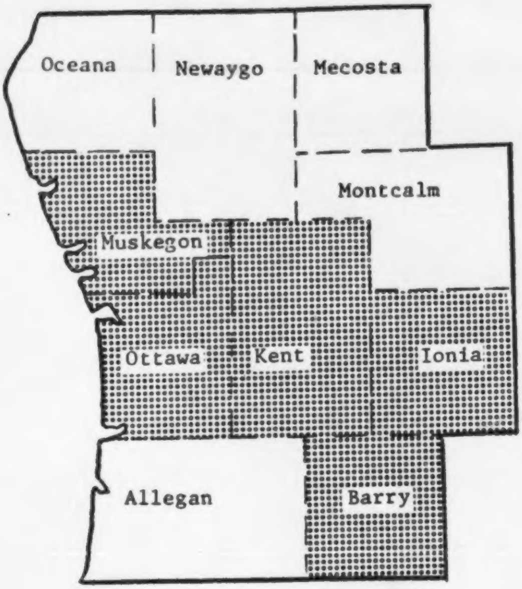
Subcontractor:

DELTA COLLEGE

Enrolled		118
Completed		
Home	17	
Center	101	
TOTAL		118

MAP D

COUNTIES IN WHICH SPECIFIC SUBCONTRACTORS OFFERED TRAINING


Oceana
Newaygo
Mecosta
Montcalm
Muskegon
Ottawa
Kent
Ionia
Allegan
Barry

Subcontractor: ▩

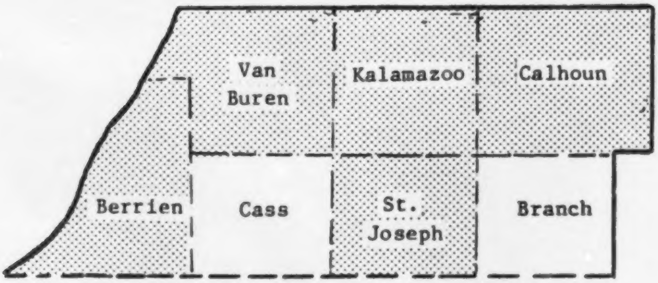
GRAND VALLEY (KIRKHOF COLLEGE)

Enrolled		186
Completed		
Home	37	
Center	99	
TOTAL		136

Subcontractor: ▒

KALAMAZOO VALLEY COMMUNITY COLLEGE

Enrolled		179
Completed		
Home	17	
Center	124	
TOTAL		141


Van Buren
Kalamazoo
Calhoun
Berrien
Cass
St. Joseph
Branch

MAP E
COUNTIES IN WHICH SPECIFIC SUBCONTRACTORS OFFERED TRAINING

▩ Family Day Care Council
Mercy College

▦ Family Day Care Council
University of Michigan

▧ University of Michigan

░ Wayne County Comm. College
FAC (WSU)
Mercy College

Subcontractor:

UNIVERSITY OF MICHIGAN

Enrolled 141

Completed
Home 17
Center 65
TOTAL 82

Subcontractor:

FAMILY DAY CARE COUNCIL

Enrolled 64

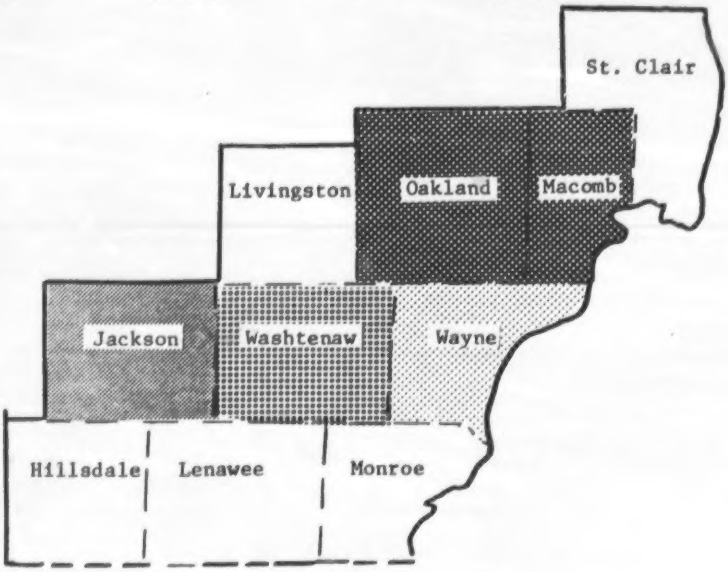
Completed
Home 61
Center 0
TOTAL 61

Subcontractor:

MERCY COLLEGE

Enrolled 230

Completed
Home 39
Center 131
TOTAL 170


St. Clair
Livingston
Oakland
Macomb
Jackson
Washtenaw
Wayne
Hillsdale
Lenawee
Monroe

Subcontractor:

FAC (WSU)

Enrolled 14

Completed
Home 13
Center 0
TOTAL 13

Subcontractor:

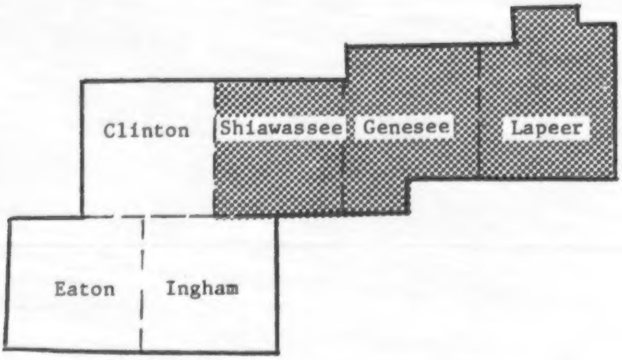
WAYNE COUNTY COMMUNITY COLLEGE

Enrolled 91

Completed
Home 15
Center 60
TOTAL 75

MAP F

COUNTIES IN WHICH THE SUBCONTRACTOR MOTT OFFERED TRAINING


Clinton
Shiawassee
Genesee
Lapeer
Eaton
Ingham

Subcontractor:

MOTT COMMUNITY COLLEGE

Enrolled		110
Completed		
Home	36	
Center	61	
TOTAL		97

Table 8-A

Trainee Session Perceptions by Item and by Training Session

Session	Number	Item											
		One		Two		Three		Four		Five		Six	
		Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
One	1314	4.33	.65	4.24	.71	4.05	.82	4.01	.89	4.11	.83	4.18	.81
Two	1307	4.38	.66	4.33	.69	4.08	.86	4.25	.80	4.33	.71	4.34	.76
Three	1224	4.43	.66	4.36	.65	4.14	.86	4.34	.77	4.42	.71	4.40	.71
Four	1170	4.47	.61	4.34	.73	4.18	.88	4.34	.73	4.39	.70	4.42	.71
Five	1014	4.48	.62	4.40	.69	4.26	.85	4.35	.75	4.45	.69	4.43	.74
Six	794	4.44	.66	4.37	.72	4.14	.92	4.33	.78	4.34	.76	4.41	.75
Seven	442	4.44	.70	4.38	.73	4.23	.83	4.35	.77	4.38	.77	4.43	.71
Eight	334	4.37	.69	4.31	.69	4.20	.82	4.23	.78	4.24	.78	4.28	.78
Nine	181	4.39	.68	4.27	.76	4.17	.86	4.37	.76	4.31	.82	4.38	.75
Ten	107	4.42	.70	4.38	.70	4.35	.70	4.32	.73	4.17	.81	4.39	.69